HOSPITAL ABSTRACTS

A MONTHLY SURVEY OF WORLD LITERATURE

PREPARED BY THE DEPARTMENT OF HEALTH

AND SOCIAL SECURITY

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HOSPITAL ABSTRACTS

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HOSPITALS IN OTHER COUNTRIES

See also Abstract Nos. 940, 966

932. BRACHER, E. Allgemein-Betten in Privatspitälern - eine Notwendigkeit? **[General beds in private hospitals: a necessity?]** *Veska*, Aarau, 1979, Feb., vol. 43, no. 2, pp. 94-95.

General beds in this context are defined as hospital beds in private hospitals for which the charges correspond to those of the nearest public hospital. Such beds have been provided in Swiss private hospitals for some time. The conclusion of this paper is that co-operation in this way between the private and the public sectors is essential if the best use is to be made of existing facilities.

PLANNING, DESIGN AND CONSTRUCTION

See also Abstract No. 977

933. LIND, B. Elementer af en planlägningsmodel. **[Elements of a planning model.]** *Tidsskrift for danske Sygehuse*, Glostrup, 1978, Nov./Dec., vol. 54, no. 10, pp. 172-178.

Satisfactory results of planning work can never be attained without active co-operation between decision-makers and planners. Lacking concrete forecasts of future developments in disease and treatment, traditional plans are based on a review of the present state of the art, usually out of date by the time the plan is carried out. The Danish Hospitals Institute has evolved a Requirements Forecasting Model to clarify relationships between selected planning factors and the need for various forms of health service facility. Such determinant factors comprise: the population basis; developments in the medical and medico-technological fields; division of labour between hospital, primary health service and related services; co-ordination of the above concepts; and political and professional attitudes to the current and future structure of the system. Comparison of informed team forecasts of the expected extent of medical and nursing care, and examination of therapeutic and consultation facilities within the present capacity allows the need for investment in buildings, apparatus, beds and staff to be analyzed. Forecasts of morbidity are based on the age distribution in the population, trends in urbanization, and the socio-economic climate, plus factors affecting examination and treatment of patients and preventive medicine. Forecasts are based on Delphi study enquiries amongst experts who are first asked their opinions independently of one another, and subsequently discuss each others' replies as a team. The article is illustrated with schematic diagrams summarizing the concepts discussed.

934. POULSEN, H. Betragtninger over eksisterende sygehusplaner. **[Reflections on existing hospital plans.]** *Tidsskrift for danske Sygehuse*, Glostrup, 1978, Nov./Dec., vol. 54, no. 10, pp. 164-172.

The Danish Hospitals Institute has published a report entitled 'Sygehusplanlägning, Vurdering af sygehusplaner, Planlägningsmetode' (Hospital planning, assessment of hospital plans, planning method). The project group carried out a systematic analysis of eight Danish county hospital plans and one Swedish one. The analysis was subdivided into method, aims, organization, status, requirements, way in which plan is presented (including any alternative plans), content of plan, and ability to revise plan at a later stage. This latter concept was regrettably lacking from most plans—despite the fact that nearly all plans state that it is necessary. Planning ought to be carried out block by block (e.g. by specialty or by diagnosis) rather than from the foundations up. Forecasts of expected future requirements are far too uncertain a foundation on which to base concrete plans. Planning must be organized in such a way as to ensure that the correct people are given the opportunity of influencing the planning process at the relevant stage(s). Analyses of the present state of the art in various specialties, departments etc. are far too detailed, far too voluminous and far too time-consuming, and have little relation to future health needs. In general, too little attention is paid under this heading to general practice or the social sector. No viable organization plan has yet developed, and plans show a remarkable lack of comparability and clarity, especially as regards budgeting and staff requirements. The article is accompanied by tables summarizing the various factors analyzed and proposing a modified order of hospital planning.

HOSPITAL DESIGN

935. HILARIO, E. **Comfort and surroundings in hospitals.** *Hospital Engineering*, London, 1979, March, vol. 33, no. 2, pp. 20-22, 24-25.

The author outlines the history of Portuguese hospitals from the earliest beginnings under the religious orders to the increased intervention of the State from about 1886 to the present day. The Statute for Social Welfare Work of 1944 divided the country into zones with regional and sub-regional hospitals. Specialized hospitals with medical schools are situated in Lisbon and Oporto, but are in need of modernization. Methods of re-modelling old hospitals to suit conditions in Portugal and give patients and staff greater comfort need to be considered. As the total cost of equipment usually equals that of construction, the choice of cost-effective equipment is vital. Buildings should be flexible to provide for new needs and developments and should create an environment which is reassuring for the patient. Health centres are now being built in Portugal to reduce the work load of the hospitals.

936. RIZZO, A. and DADDI, I. H.S.M. un sistema per la realizzazione di ospedali. **[H.S.M. a system of hospital design.]** *Veska*, Aarau, 1978, vol. 42, no. 10, pp. 561-567.

A description is given of a modular system of hospital design. The author stresses one particular feature, namely that corridors running along the outside of the ward block are not at the same level as the patients' rooms and do not therefore interfere with the

view of the latter. The system is described with the aid of two diagrams, four scale drawings, and two photographs of models for a proposed new hospital in Genoa.

DESIGN OF INDIVIDUAL GENERAL HOSPITALS

937. MONTALBAN, J. and LEFEVER, C. Le Centre Hospitalier Régional de Dijon. **[The Dijon Regional Hospital Centre.]** *Gestions Hospitalières*, Mantes-la-Jolie, 1979, Jan., no. 182, pp. 47-50.

This is an account of the gradual expansion and renovation of the regional hospital in Dijon over the past 15 years; 1,250 new beds, 450 new places in training schools for paramedical staff, and 150 rooms for staff have been provided, 350 beds 'humanised' and 200 sanatorium beds brought into use again. In addition to the original 500-bed Bocage hospital, a 125-bed maternity block, a 317-bed paediatric block, a centre for cardiological medicine (96 beds), a transfusion centre, and an administrative block have been built on the 23 hectare site. The Faculty of Medicine and Pharmacy and the Centre for the Campaign against Cancer adjoin the hospital site and a convalescence and rehabilitation centre (120 beds) has just been opened. Each block is functionally autonomous and is built on a manageable, human scale. A further 400-bed block for vascular diseases is now taking shape.

938. Zur Einweinung der Klinik Stephanshorn, St. Gallen. **[Official opening of the Stephanshorn Clinic, St. Gallen.]** *Veska*, Aarau, 1979, Feb., vol. 43, no. 2, pp. 89-91.

The official opening of the new 75-bed Stephanshorn Clinic, St. Gallen, took place in December 1978. Each of the three upper floors has one ward unit, divided into two nursing groups of eight to 15 beds each. Apart from the fact that all maternity patients are concentrated on the second floor, the medical specialties are not separated. There are five four-bedded, one three-bedded, 30 one- or two-bedded, and five single patients' rooms: the 30 one- or two-bedded rooms can be single or double according to need. Patients are treated while in hospital by the doctor who referred them.

939. Försörjningscentral i Karlstad topprustad. **[Completion of Karlstad (Hospital) services centre.]** *Landstingens Tidskrift*, Stockholm, 1979, Feb., vol. 66, no. 3, pp. 30-31.

Wermland County Central Hospital in Karlstad has opened a new central services facility as the first stage of a series of extensions planned to continue through the 1980s. The centre comprises a central kitchen, serving 5,000 portions (30 menu items) a day to the hospital and other county institutions; a 350 place canteen and cafeteria; a cleaning centre; a 550 m^2 library plus teaching accommodation, a closed circuit television room and lecture hall; and an admissions centre. Food is served centrally on trays in accordance with punched diet cards, and there are automated food and drinks dispensers for night staff. The cleaning centre has high pressure apparatus for rapid cleaning of curtains, mops, trolleys and floors. There are offices for the hospital chaplain, the curator, and the patients' (elected) representative. The new otorhinolaryngology admissions department has a specially ventilated room for allergy cases; teaching, technical and testing rooms for the deaf, including computer-controlled

audiometry equipment; and offices for the deaf and dumb interpreter. In addition, there is new accommodation for the skin clinic, the cancer clinic (including an 18 mEv linear accelerator costing s.kr. 4 million), and a fully sound-insulated orthopaedics workshop. The plaster room has a highly efficient extractor fan system to prevent irritating vapours. All refuse is burnt at the rate of 350 kg. an hour at 1,400°C, the heat being used to heat the hospital. There is also a 2 million watt refrigeration set for cooling the air in summer. All categories of staff were involved throughout the planning stage. The article is illustrated with three photographs.

940. KRISTIANSEN, K. **Sunnaas hospital 25 years: the story of a rehabilitation centre.** *Journal of the Oslo City Hospitals*, Oslo, 1979, Mar., vol. 29, no. 3, pp. 24-34.

The Sunnaas Hospital and Rehabilitation Centre for the Physically Disabled was founded in Oslo in 1854, extended to include modern facilities for physiotherapy and occupational therapy in 1960 and 1966, and finally extended to 247 beds in 1974. The hospital receives substantial financial support from Oslo City. The rehabilitation centre cares for patients suffering from disabilities following injuries and diseases of the brain, spinal cord and the musculoskeletal system. A large proportion of patients are transferred from Ullevål Hospital. Each year about 1,200 patients are admitted, the average length of stay in 1977 being 59 days. The programme for paraplegics and quadruplegics has been very successful in returning patients to some kind of employment. The hospital has a special spinal cord unit and an Institute of Aphasia and Stroke, largely concerned with the study of aphasic disturbances. The hospital's clinical, teaching and research activities have been widely reported in rehabilitation literature, and some of the studies carried out and courses given are described in the article.

941. LAAGE, G. Neubau mit 190 Betten "Kinderklinik" in Esslingen. **[The new 190-bed children's department at Esslingen.]** *Krankenhaus*, Stuttgart, 1978, Dec., vol. 70, no. 12, pp. 470-472.

The new children's block at the Esslingen Municipal hospital is of three storeys. There are 140 general paediatric beds and 50 surgical beds: each of these areas is divided into four groups: (i) intensive care; (ii) newborn and premature infants; (iii) infants; (iv) young children and schoolchildren. All ward units are surrounded by terraces from which there is access for visitors; to all rooms. There are separate subways for clean and dirty material linking with the main hospital. Separate entrances are provided for: out-patients, staff and visitors; stretcher cases; and infectious cases; there are also separate routes for in-patients, out-patients and visitors. Each ward, patient's room or group of rooms can be used as an isolation unit for infection. The 7 m. by 7 m. module allows great flexibility.

942. PETER, E. Klinikneubau in Minden: Kindgerecht und farbenfroh! **[The new Children's Hospital at Minden: suitable and colourful.]** *Krankenhaus*, Stuttgart, 1978, Dec., vol. 70, no. 12, pp. 466-470.

The new 103-bed children's hospital at Minden came into use in September 1978. On the ground floor are 25 beds for infectious diseases (rooms are shared by children suffering from the same disease and of the same age group); the first floor has 24 beds

for toddlers and school children; the second floor has 27 beds for infants; and the third floor has 27 beds for the newborn. The patients' rooms have windows looking onto the corridor, after the style of a railway train; and window frames and doors are in bright colours. Treatment areas are on the ground floor and a subway links the building with the women's hospital which supplies meals, laundry and drugs. Entrance hall and corridors are brightly decorated with birds, animals and landscapes. The paper is illustrated with a plan of each floor and two photographs.

ENGINEERING SERVICES

INSTALLATIONS IN GENERAL

943. FLURY, J. La surveillance centralisée des installations techniques. **[Centralized control of engineering services.]** *Hospital Engineering*, London, 1979, March, vol. 33, no. 2, pp. 15-19.

Vaudois University Hospital Centre, Switzerland, consists of 20 different buildings with a total capacity of 1,350 beds. Centralized control of engineering services installed in 1970, has provided a board in each building on which are situated different technical alarms connected to the main boards of each service and to the main telephone switchboard, which informs maintenance staff when an alarm occurs. Although satisfactory, the system does not allow either certain actions or energy savings. The 900 beds in the new building have a more efficient system which provides continuous control by systematic and permanent scanning of all data. It announces and registers alarms, indicating the degree of emergency. The installation consists of a control console (table, scheme projectors, printing machine, screen and printer), auxiliary stations and circuits. Each alarm is visible on the screen and printed. The particular installation can be put on the screen, so one can see immediately the type of fault, and can eventually resolve it by remote control. The computer can provide a list of faults, according to emergency priorities, repair sheet works orders, etc. Nine diagrams are included.

COMMUNICATION SYSTEMS

See also Abstract No. 943

944. NOLL, A. M. and WOODS, J. P. **The use of Picturephone service in a hospital.** *Telecommunications Policy*, Guildford, 1979, Mar., vol. 3, no. 1, pp. 29-36.

The Picturephone system provides switched audiovisual communications between any two terminals on the network through the use of an associated Touch-Tone telephone for dialling. The terminals consist of a black-and-white television camera and a small screen monitor with a five-inch square picture. The system was operational from March 1973 to April 1976 in the Bethany-Garfield Hospital, Chicago. Metered usage was as high as 1,800 calls per month. When hospital staff were asked to rate a number of individual features of the system, the high and medium users rated the fast access feature above all others. Thus the main reason for the high usage of the Picturephone system appears to have been less related to its visual communications feature than to its 'hot-line' capabilities to reach contacts quickly.

945. LOVETT, J. E. and BASHSHUR, R. L. **Telemedicine in the USA: an overview.** *Telecommunications Policy*, Guildford, 1979, Mar., vol. 3, no. 1, pp. 3-14.

This paper examines the development and use of telecommunications technology in the provision of health services and in that context discusses policy formulation relating to technological innovation in health care. In the course of this examination, the authors consider the nature of the major challenges facing health care delivery that are amenable to responses in telecommunications technology, present selected findings from telemedicine studies in the light of these challenges, and offer a set of policy recommendations.

946. ROCKOFF, M. L. and BENNETT, A. M. **The patient trajectory: a modelling tool for planning rural telemedicine systems.** *Telecommunications Policy*, Guildford, 1979, Mar., vol. 3, no. 1, pp. 15-28.

This paper presents an analytical tool developed and applied in order to plan for the use of telecommunications technology to link a non-physician health care provider in a rural satellite clinic to a central source of medical expertise. The model involved the use of a 'patient trajectory'—the path that a patient follows as he interacts with the health care system. The principal result obtained is that narrowband technologies appear to be nearly two-thirds as effective as broadband technologies in averting patient travel.

TRANSPORT IN GENERAL

See Abstract No. 1057

HEATING

See also Abstract No. 979

947. HORNAK, J. P. and KNIGHT, K. **Solar energy retrofit revisited: what the VA has learned in a year's operation of a solar heating and cooling system.** *Heating/Piping/Air Conditioning*, Chicago, 1979, Jan., vol. 51, no. 1, pp. 85-88.

The solar heating and cooling system at Veterans Administration Hospital, Wilmington, Del., has 5,000 net square feet of double-glazed flat plate solar collectors, which are used both to heat and cool the two-storey research buildings. Approximately 50 points are monitored and recorded, and the data from these points are being used to assess the performance of the system. Data for some typical days in the first year of operation are discussed. It was found that the system is operating at thermal efficiencies lower than those predicted by the design calculations. A number of points worth considering in any future design are presented.

VENTILATION AND AIR CONDITIONING

See also Abstract Nos. 947, 1014

948. DeROOS, R. L. **Environmental health and safety concerns and energy conservation practices in academic institutions and hospitals.** *American Journal of Public Health*, Washington, D.C., 1978, Oct., vol. 68, no. 10, pp. 1011-1015.

In spite of the energy conservation practices now being applied in hospitals and

academic institutions, there will be additional pressures for further reductions in energy use. In many instances, these reductions in energy use can be carried out within existing standards and without endangering the health of people in institutions. The background relating to hospitals; ventilation standards for a complex hospital environment; the ventilation of hospital laboratories; and the recommendations regarding water temperature are outlined. The need for those involved in energy conservation to be aware of the potential adverse effects is discussed.

EQUIPMENT, FITTINGS, FURNITURE

BEDS, COTS, ETC.

949. KVORNING, S. A. Vand- og luftmadrasser til forebyggelse af tryksår: värdifuld men ikke fuld beskyttelse. **[Water and air mattresses are valuable but not completely successful in preventing pressure sores.]** *Sygeplejersken*, København, 1979, Mar. 21, no. 12, pp. 4-7.

The Skin Clinic at Copenhagen Kommunehospital assessed the two types of anti-decubitus mattresses available—water and alternating air pressure—in comparison with normal spring mattresses over a period of seven months in 1977. Out of 3,571 acute admissions, 58 patients had bedsores on admission and were not included in the investigation. Six hundred patients were assessed for risk of bedsores by a modification of the Mary Bliss method and allocated to beds of the three different types—normal, air and water beds. Criteria for selection were: unconsciousness, dehydration and paralysis plus two of the following criteria: age over 70; limitation of movement; incontinence; gross thinness; and rubor over pressure areas. Every other day for the first 10 days patients were checked for naturalness of skin, redness, infiltration, blebs, black necroses or epithelial defects. Thirty five of the 600 patients selected contracted bedsores but none of the 2,916 others did so, proving the efficiency of the method of selection. Twenty one out of 161 patients on ordinary mattresses (13 per cent) developed bedsores; seven out of 166 (4.2 per cent) were on alternating pressure air mattresses and seven out of 155 (4.5 per cent) were on water mattresses. The air and water mattresses assessed comprise a valuable but not completely efficacious protection against bedsores. The article is illustrated by a photograph of each of the two types of bed.

EQUIPMENT GENERALLY

950. NIELSEN, H. Sygehuse og produktansvar. **[Hospitals and legal liability for the use of equipment.]** *Tidsskrift for danske Sygehuse*, Glostrup, 1979, Feb., vol. 55, no. 2, pp. 13-15.

A product may give rise to a product responsibility claim (Produktansvar) if the product, while in normal use, causes an injury as a result of being more dangerous than other comparable products. The concept does not cover medicines, nor *ex lege artis* treatment not resulting in the patient's recovery. Legal experts distinguish between two main groups of faults and failure in apparatus. The first (A) covers faults in design;

user instruction; construction; and delivery. The responsibility rests on proof of culpability, before damages can be allotted. The second group (B) covers developmental injuries, i.e. injuries caused by unknown danger factors (e.g. radiation damage caused in the early days of X-rays); and systematic injury, caused by known but unavoidable dangers—'the patient's risk'. The manufacturer cannot be held responsible for injuries occurring under category B. No manufacturer or supplier has ever been ordered by the Danish courts to pay damages to any patient for injuries received, but several hospitals have had to pay compensation to patients or to their surviving relatives. This is because most injuries which may occur will be found to have been caused by faulty prescription or application of treatment with the apparatus concerned. Staff are responsible for observing the patient throughout treatment and taking appropriate action on any departure from the expected effect. The administration must consult staff (the users) before purchasing equipment, and insist on apparatus being designed to show up any fault in function before it can do damage. The hospital must also insist on the manufacturer's responsibility for information, repairs and maintenance being laid down in the purchasing contract.

ELECTRONIC EQUIPMENT

951. DONALD, I. **Ultrasonics—a new diagnostic dimension.** *Hospital & Health Services Purchasing*, London, 1979, Feb., pp. 48, 50.

Ultrasonic echo sounding is gaining rapid acceptance as a routine diagnostic procedure, the action of which is briefly described. Research and development in Britain over the last 20 years has largely been pioneered by the author and his engineering colleagues. The original A-scan technique is still used for measuring the diameter of the foetal skull: the more sophisticated B-scanners make ultrasonograms of organ outlines and their tissue characteristics using a scan converter. Different types of scanning machines are best suited to different medical needs and the running costs are determined by the method of photographic recording employed. The widely used Emisonic 4200 provides a reliable general purpose machine. Real time scanning is a recent development, making possible the study of the behaviour of a given organ or structure. These scanners are of two main types, the linear array system, or the more versatile single-window radial approach. Scanning is acceptable to patients because it involves minimum preparation and no discomfort.

STAFF GENERALLY

STAFF COMPLEMENTS

See Abstract Nos. 957, 958

RECRUITMENT AND MANPOWER

See Abstract Nos. 959, 964

CONDITIONS OF SERVICE

See Abstract No. 959

STAFF MANAGEMENT

See also Abstract Nos. 954, 965, 966

952. BENNETT, A. C. **Education and training need to be brought up-to-date.** *Hospitals*, Chicago, 1978, Dec. 16, vol. 52, no. 24, pp. 75-76, 84.

Training of hospital staff consumes a large segment of total expenditure so it is important to document clear proof of value. If training programmes are to be successful, they must be relevant to the measured needs of the institution. In addition to this essential characteristic of the training process, six others that affect the outcomes of training programmes are discussed: (i) it must be perceived and carried into effect as a systemic process; (ii) top management must be involved; (iii) the corporate training function must be managed effectively; (iv) adoption of a 'learning by doing' philosophy; (v) practical application of trainee and trainer accountability; and (vi) a humanistic approach is required in the development of training programmes to give proper balance between human and technical concerns and considerations within the hospital's work environment.

953. GRUBB, A. W. **Hospital takes systematic approach to educational programs.** *Hospitals*, Chicago, 1978, Dec. 16, vol. 52, no. 24, pp. 78, 81, 84.

After an analysis of its educational programmes showed them to be deficient, Deaconess Hospital, Evansville, Ind., undertook the development of a comprehensive, systemic programme of education and training. The first step was the establishment of an independent department of education at the upper management level in the hospital's organizational hierarchy and its staffing with a manager and staff with professional expertise in training. An official policy document on the use and value of training programmes was then prepared and circulated throughout the hospital. A hospital educational advisory committee was formed, with representative department heads as members. The advantages of this approach to management of the training function are discussed.

STAFF TRAINING

See also Abstract Nos. 952, 953, 960, 967-970

954. HOFFMANN, M. Grundsätzliche Erwägungenzum Problem des Spital-Managements. **[Basic considerations on the problem of hospital management.]** *Österreichische Krankenhaus-Zeitung*, Wien, 1979, Jan., vol. 20, no. 1, pp. 45-49.

The primary aim of hospital management—to provide optimal care for the patient—is complicated by the fact that there are eight professional groups of staff (with doctors playing a specially important role) and that the hospital is normally controlled by a central administrative body. The author sets out in tabular form a 'phototype strategy for improving hospital management and rationalizing hospital performance'. This

takes the form of a series of 15 'steps' from a situation analysis via a number of training courses of various types to an assessment of results. The objective, method and period of time required are given for each 'step'.

STAFF WELFARE

See Abstract No. 1016

SPECIAL CLASSES OF STAFF

ADMINISTRATIVE AND CLERICAL STAFF

955. BORGENHAMMAR, E. Ledarskap i Förendring: vad kan sjukvårdsadministratören göra? **[Leadership in a state of change: what can hospital administrators do?]** *Norsk Sykehustidende*, Oslo, 1979, Jan., vol. 52, no. 1, pp. 22, 24, 26, 28-29, 31, 32.

The administrator's work comprises dealing with series of external and internal conditions which are felt to be unsatisfactory rather than with structured problems. The important thing about new thinking is not that it should be new but that it should be more relevant and more reliable. The administrator's main task is to stimulate change. Change can be induced in various ways by: the informative model, by logical induction of a cognitive process; the related evolutionary model, based on affecting employee aims and ambitions; the incitement (financial or status gain) model; the power model; and the inspiration model. Improvements are not always the ones planned by the administration, nor do they always arise in a planned or logical manner. There must be freedom and flexibility in the system for the use of initiative; rigid planning can kill a dynamic enterprise. Economy is not always synonymous with good administration: over-economy can prevent the achievement of legitimate aims. The highest ambition of the administrator is to be able to provide trusted employees with a series of aims, and the freedom and resources to carry them out.

MEDICAL STAFF

See also Abstract Nos. 971, 991, 1044, 1062

956. VAN GIFFEN, H. Der Mediziner in der Struktur des Krankenhauses. **[The doctor and the structure of the hospitals.]** *Österreichische Krankenhaus Zeitung*, Wien, 1979, Jan., vol. 20, no. 1, pp. 34, 37-39.

The structure and organization of hospital medical staff in the various European countries is compared and the considerable differences in training, types of appointment and recommendation discussed. Other factors which are common to all countries are also outlined. These include: increasing technological advances; increasing specialization leading to 'team treatment' with non-medical professionals as members of the team; increasing concentration of specialist treatment in hospitals; and the need for inter-hospital co-operation to ensure the best use of resources.

957. JENNETT, B. **How many specialists?** *Lancet*, London, 1979, Mar. 17, vol. i, pp. 594-597.

The need for specialists cannot be adequately assessed on the basis of current practice and an estimated case-load (based on prevalence/population ratio). Specialists should declare which patients can or cannot be expected to benefit from their treatment, and they should consider the consequences of under-provision of specialist services. Specialists should also decide how much of what they normally do might equally well be carried out by generalists using the knowledge of specialists. Only then can the appropriate level of provision for various specialties be assessed, and effective deployment of the resources provided ensured.

958. PARKHOUSE, J. **Medical manpower two years on.** *British Medical Journal*, London, 1979, Mar. 3, vol. i, pp. 595-596.

Following a two-year forecast on medical manpower made in 1975, the author analyses the actual manpower level for the years 1976 and 1977, with particular reference to the National Health Service. The output of British medical schools increased as predicted. The total number of doctors in the NHS rose by two per cent between 1975 and 1976 and by 2.4 per cent between 1976 and 1977. The highest and lowest growth rates were in junior and senior hospital staff grades respectively, while the highest growth in the career grades seemed to be in community medicine. The total number of foreign doctors was 247 more in 1977 than in 1976, but most overseas doctors do not intend to remain in Britain for long. Continuous evaluation of the medical manpower position is needed before long-term predictions can confidently be made.

959. WILLIAMS, D. I. **Revised career structure: first priority.** *British Medical Journal*, London, 1979, Jan. 13, vol. i, pp. 144-145.

There is an urgent need to alter the career structure for doctors and the hospital staffing structure in general. The priorities must be to: (i) reduce the number of registrars; (ii) adjust the time spent in this grade; and (iii) facilitate moving from one specialty to another. All doctors who have passed through the training grades to positions of responsibility should be given the status of consultants. In a staffing structure containing more consultants, a grade of senior consultant would be necessary. Length of service would be a factor in attaining seniority, but greater mobility between hospitals should be encouraged. An increased number of consultants would result in better continuity of care in out-patient clinics. To facilitate the introduction of the new structure, registrars of four years standing should be offered supernumerary senior registrar posts of limited tenure to enable them to apply for consultant posts. The Department of Health and Social Security must provide facilities for doctors to attain the high standards expected of British medicine.

960. MAZMANIAN, P. E. and PENNINGTON, F. C. **Where to look when assessing CME needs.** *Hospital Medical Staff*, Chicago, 1978, Sept., vol. 7, no. 9, pp. 10-15.

Although an increasing number of continuing medical education courses are being held in hospitals in the United States, there is little information available to help either physicians or course planners to assess current educational needs. This article provides

a framework to use in conducting needs assessment and suggests readily available sources of information. Individual physicians may wish to explore a particular area further or, by comparing their hospital with another, may discover areas of deficiency. The author lists some useful data sources, including: (i) results of cognitive testing; (ii) interviews with experts in certain topics; (iii) reports of research findings; (iv) reports of deficiencies revealed by peer review; and (v) statements from professional societies and government agencies regarding current medical and public health problems. Well planned continuing medical education courses based on local educational needs held in the community hospital should result in more effective use of hospital staff resources.

961. BLANPAIN, J. E. Der Arzt und das Krankenhaus: ein Programm der Alternative. **[The doctor and the hospital: a programme of alternatives.]** *Österreichische Krankenhaus-Zeitung*, Wien, Jan., vol. 20, no. 1, pp. 40-43.

A brief account is given of the attitude of the medical profession in European countries to the introduction of national health insurance and health service systems. Doctors had pressed their case for independence, the right to private practice and to a say in hospital administration. Health service policy aims at reducing hospital costs by such measures as providing more out-patient and less in-patient care and more preventive medicine. What is needed is agreement with the medical profession on a definition of the problems to be solved before solutions to them are sought.

962. BARON, D. N. **Medical careers in pathology, 1977.** *Journal of Clinical Pathology*, London, 1979, Jan., vol. 32, no. 1, pp. 11-15.

A survey was made, mainly covering the second half of 1977, of career grade posts and senior training posts in pathology in the United Kingdom. The survey covered all disciplines of pathology and all types of employment (National Health Service, medical school, and many others). The survey also examined the number of applicants for advertised posts and the number of posts left vacant. The results are presented in two tables and discussed; they are also compared with an earlier survey and with surveys in other specialties. There were variations between disciplines and between regions; microbiology and Northern Ireland had most failures in filling posts. Overall, about three per cent of career grade posts and 15 per cent of training posts were left unfilled.

NURSING STAFF

963. HALL, D. J. **'What nurse don't see, she don't worry about', or the use of observation in hospital research.** *Nursing Times*, London, 1978, Dec. 7, vol. 74, no. 49, occasional papers, p. 137-140.

The author discusses the value of observations as a method of data gathering for research, with particular reference to the use of observation in children's wards. Three types of observation are discussed: (i) case studies; (ii) ward studies; and (iii) incidents and accounts. The first type selects individuals and observes them throughout their stay in hospital. Prepared coding sheets were used to record children's activities and behaviour at certain times. The studies showed that (i) children expected an increase

in play when a playleader was introduced and; (ii) contact with parents was inversely related to contact with nurses. Using a simple classification of children's activities, the author observed two slightly different types of ward for one week. Again the introduction of a playleader increased activity. Observing particular incidents is sometimes useful but does not give an overall picture of ward life. There is a case for using observation as a method of training nurses to take an objective view of those actions which affect others.

964. GRAY, R. and SAUER, K. **Analysis and planning for improved distribution of nursing personnel and services: nursing resources and requirements: a guide for state-level planning.** Boulder, Colo., Western Interstate Commission for Higher Education and National Center for Higher Education Management Systems, 1978, xi, 328pp.

This report describes new ways of achieving more equitable distribution of nursing staff and services and new ways of determining the appropriate dimensions and characteristics of the nursing component in health-care delivery. A new methodology for projecting nursing requirements and resources for meeting these requirements at the state level is described. The report is in four sections and considers: the requirements planning process; requirements projections; resources planning process; and resources projections process. An appendix is included outlining assumptions, rationale, estimates and calculations for public health nursing requirements. There is also a bibliography (pp. 311-325) and an annotated bibliography for the Analysis and Planning project (pp. 327-328).

965. MELIA, K. M. **A sociological approach to the analysis of nursing work.** *Journal of Advanced Nursing*, Oxford, 1979, Jan., vol. 4, no. 1, pp. 57-67.

This paper describes, from a sociological perspective, the work of ward nurses. An analogy is drawn between the work organization of miners at the coal-face and that of nurses in the wards. Work roles are considered in order to provide a framework for the analysis of the work of nurses. Multi-skilled and single skilled work roles are described and the concept of a hierarchy of nursing tasks is considered. Problems of observing and analyzing the work of nurses are highlighted with particular reference to the type of environment in which hospital nursing takes place.

966. SMITH, H. L., DISCENZA, R. and SAXBERG, B. O. **Nurses' perspectives of decision making in nursing homes.** *Journal of Long-Term Care Administration*, Washington, D.C., 1978, vol. 6, no. 4, pp. 1-12.

The pattern of decision-making carried out by nurses in nursing homes was studied by means of surveys completed by 132 nursing staff from 30 nursing homes in the State of Washington. The study showed that nursing directors communicated frequently with administrators and took part in making decisions, especially when attitudes towards patients or levels of nurses' pay were involved. Decision-making was also sometimes initiated by nursing directors. Licensed nurses and nurses' aides took little part in pay decisions, but considered they were involved in decisions affecting total patient care. Seventy-eight per cent of licensed nurses were allowed to make decisions in administering drugs. The majority of nurses considered that charge nurses had the most influence on nursing services, followed by the administrator and the nursing

director. As nurses at all levels clearly wish to maintain high standards in nursing homes, patient care would probably benefit from greater nurse participation in formal decision-making.

967. JONES, D. C. and KEIGHLEY, A. C. **Applications to undergraduate nursing courses.** *Journal of Advanced Nursing*, Oxford, 1979, Jan., vol. 4, no. 1, pp. 79-85.

Education of nurses has in recent years developed in centres of higher education, but with a rapid rise in courses offered, concern has been expressed that too few suitable applicants may be available. This study has attempted to ascertain actual demand for the courses available by cross-referencing applications to a sample of courses. It shows a downward trend of suitable applications over the two years 1975 and 1976. A cautionary approach to establishing new courses or increasing numbers on existing courses may be advisable and further comparable work will be carried out to assess the validity of the trends already found.

968. SHEAHAN, J. **Measurement in nursing education.** *Journal of Advanced Nursing*, Oxford, 1979, Jan., vol. 4, no. 1, pp. 47-56.

Evaluation is put into perspective, including measurement and assessment, in relation to the curriculum as a whole. The elements included in the evaluation of educational programmes are outlined. The process of evaluation is related to learning abilities in the cognitive, affective, psychomotor and experimential domains. Underlying all discussions about measurement in nursing education are two important and related concepts—standards of patient care and entry to the nursing profession. From these emerge two very important questions. Can we measure? Should we measure? Abilities can be measured and should be measured, but those concerned with nursing education should not confine themselves only to measurement. Nursing uses formative tests, such as practical nursing assessments, and summative tests in the form of objective items and essay-type questions. This combination has much to commend it but will, of course, have to be kept under review in the light of research findings.

969. GARAIG, M. and GILLODES, G. Les méthodes pédagogiques modernes dans l'enseignement des soins infirmiers. **[Modern teaching methods used in teaching nursing skills.]** *Gestions Hospitalières*, Mantes-la-Jolie, 1979, Jan., no. 182, pp. 17-30.

Training for student nurses at La Capelette, Marseilles, is divided into three sections: (i) human relations, attitudes and behaviour; (ii) basic sciences; and (iii) care techniques, learnt on the job; and also into six separate stages totalling 2,152 hours of practical training and 1,328 hours of theory. Many audio-visual techniques are used as an aid to teaching; these range from the old-fashioned but indispensable blackboard, drawings and photographs, to projectors, tape recorders, slides, 16 mm. films, and video tape recorders. A dark room is used for the preparation of photographs and films, and another for the photocopying and duplicating equipment.

970. LACHEZE-PASQUET, P. La formation continue en Île-de-France. **[In-service training in the Île-de-France.]** *Gestions Hospitalières*, Mantes-la-Jolie, 1979, Jan., no. 182, pp. 41-46.

In order to meet the variety of requirements for in-service training in hospitals in

the Ile-de-France, a teaching council was established to determine which areas required priority. Training had previously been centred on the nursing staff but developments in administrative techniques and in technology have meant that other categories of hospital staff now require in-service training. In 1977, trial sessions for managerial staff and introductory courses for all new staff were held. In 1978, refresher courses on specific subjects such as computers and analytical accounting were held for managerial staff and also refresher courses for nursing staff. Training to enable staff to obtain promotion has also been introduced and generally consists of a four-day course followed by three days a month of lectures, supplemented with duplicated notes. Eighty sessions of in-service training are planned for 1979; these include promotion-oriented courses for technical and general staff.

971. LINDEN, L. Skal sygeplejersken samarbejde me lägen eller patienten. **[Are nurses to co-operate with doctors or with patients?]** *Sygeplejersken*, København, 1979, Jan. 17, no. 3, pp. 4-6.

Patients in hospital are in an anxiety state, and are frequently kept in ignorance of their diagnosis and the course of treatment intended. Doctors are unwilling to step into mental or social areas for which they have not been trained and in which they are not specialists; they prefer to work on mechanical causes which can be removed. If they cannot find such a physical cause, the patient is labelled as a hysteric or a hypochondriac. Many women become nurses because they want to work with and help people: this aim is often made difficult to achieve because of their loyalty to the doctor and his choice of treatment. Women are, however, gradually freeing themselves from their centuries-old role of acting as obedient and unquestioning servants for men, and nurses are beginning to take the initiative in providing patients with information. Medical and nursing training must include more lectures on psycho-social aspects; the public must be taught the difference between illnesses and symptoms—and symptomatic treatment.

972. THOMPSON, A. **The nursing process 1: its value for special hospital patients.** *Nursing Mirror*, Sutton, 1979, Mar. 1, vol. 148, no. 9, pp. 20-21.

The author outlines a five point plan for incorporating the nursing process in the care of special hospital patients. The first stage is assessment when the nurse must analyze the patient's problems and formulate a course of treatment to achieve long-term aims. Secondly, the nurse must record the patient's medical and social history and the events leading to breakdown. Thirdly, nursing objectives must be written into a plan which should aim at achieving a successful adjustment of behaviour. The plan is then implemented through work and recreational therapy. Finally, most staff members will be able to contribute to an evaluation of the nursing process in a closed hospital by providing information on the patient's adjustment and progress. This framework is based on experience at Rampton Hospital.

973. TIFFANY, R. **Mobilizing nursing skills.** *Journal of Advanced Nursing*, Oxford, 1979, Jan., vol. 4, no. 1, pp. 3-8.

It is argued that the practice of nursing should be based on the 'nursing model' related to care, not the 'medical model' related to care. Using the nursing model entails making an assessment of the patient's needs and an individualized care plan to

meet them. It is conceded that the historical development of nursing practice as a series of stereotyped, ritualized activities within a hierarchial profession mitigates against implementing the nursing model. However, the Royal Marsden Hospital, which specializes in the treatment of cancer, has innovated and developed the concept, and created social roles for nurses who maintain continuity of patients care from the first appointment in the hospital's out-patient clinic through to his after-care following his discharge home.

974. HARDIE, M. and HOCKEY, L. **The nursing auxiliary in the National Health Service: a policy study covering the nursing services in the UK with the exception of the psychiatric field.** Edinburgh, Scottish Home and Health Department and Department of Health and Social Security, 1978, vi, 177 pp. £3.25

The aims of the research study were to collate existing information with new information to be found on three major topic areas related to auxiliaries employed in the N.H.S.: employment and deployment; current and planned training programmes; and work patterns and job descriptions. This report presents the findings of the research study and reveals areas where further research would be of value. Three methods were used: the postal questionnaire; document analysis; and the semi-structured interview. There are seven sections which consider: the design and method of the study; current and planned instruction programmes for auxiliaries; employment of auxiliaries; work patterns of auxiliaries; policy decisions and administrative issues; an exploratory study of nurse auxiliaries; and concluding discussion. Fifty-six tables are included within the text and five appendices include details of tables; questionnaires; training schemes; job descriptions; lists of individuals and organizations consulted; and a select list of references (pp. 176-177).

OTHER PROFESSIONAL AND TECHNICAL STAFF

975. PERRY, H. B. **An analysis of the specialty and geographic location of physician assistants in the United States.** *American Journal of Public Health*, Washington, D.C., 1978, Oct., vol. 68, no. 10, pp. 1019-1021.

The development of the role of physicians' assistant in the United States during the past decade has been accompanied by the expectation that this new group of health professionals would help to lessen the shortage of primary care doctors and medical services. This report identifies those physician assistants who are more likely to have chosen employment in a primary care field or in a rural medically underserved area of the United States. The cumulative effect of the 'deployment system' developed by MEDEX for placing graduates may be seen as a useful method of improving medical services in deprived areas.

ORGANIZATION AND ADMINISTRATION

See also Abstract Nos. 961, 978, 1039, 1070

976. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. **Administrative arrangements: management games—use of management games to predict the effect of operational policies adopted for new hospitals.** (Notes on Good Practices No. 13) London, Her Majesty's Stationery Office, 1978, 8pp. £0.40

A management game was designed by the Research Team of Wessex Regional

Health Authority to predict the best method of applying management policy to the new 120-bed clinical nursing units being built in two new District General Hospitals at Southampton and Basingstoke. The Authority's policy within these units was: (i) beds would not be allocated to specific consultants; (ii) patients of either sex would be admitted; and (iii) a system of progressive patient care would be operated. The management game was also designed to be used for helping to predict how best the supporting services, e.g. delivery and service of meals, cleaning, could be managed and what problems might be encountered.

977. HOEFNAGELS, K. De functionele opbouw van de intramurale gezondheidszorg in een regio. **[Functional building up of institutional health care in a region.]** *Ziekenhuis*, Utrecht, 1979, Jan. 24, no. 2, pp. 38-42.

In planning a regional health care structure three categories of clinical functions should be distinguished. The first are top functions, such as specialized surgery, which require the highest quality and need concentration in only one or a few places within the region. The second are basic functions, which cover eight basic specialties and provide for the main sections of curative care. These include primary clinical functions such as internal surgery, gynaecology, etc. and secondary functions, such as anaesthetics, radiology, etc. These should be distributed throughout the region with easy accessibility for patients. The third are middle range functions, such as cardiology, orthopaedics, etc. whose accessibility need not be quite as comprehensive as for basic functions. The activity of the function centres depends on the type and density of population in the catchment areas and is controlled by supply and demand. The responsibility for effective regional distribution lies with the provincial authorities. These have to act in line with Government regulations, subsidies and the availability of medical specialists and facilities. Co-operation between hospitals and authorities is essential. Municipal authorities should act in the same pattern. The paper includes a table on provision of specialties per one million population and a table on demand during 1975.

GOVERNING BODIES, COMMITTEES

978. KAUFMAN, K. and others. **The effects of board composition and structure on hospital performance.** *Hospital & Health Services Administration*, Chicago, 1979, vol. 24, no. 1, pp. 37-62.

Members of the boards of 38 hospitals were categorized by occupational group, size of board, and percentage of turnover of members. Measures representing the flow of information between administration and the board were then introduced. Four variables were selected to represent cost and quality performance: non-medical support department's cost per patient day; medical support department's cost per patient day; cost per case; and quality measured by post-surgical complications rate and medical-surgical death rate. Although the findings must be considered preliminary, certain trends and conclusions emerge: larger boards are associated with higher costs; specific occupational groups on the board are not associated with a more or less efficient operation of the hospital; there is little evidence that the corporate form of governance

provides significant operational advantages; turnover rate of board membership was correlated with both cost and quality.

ECONOMICS OF HOSPITAL MANAGEMENT

See also Abstract Nos. 947, 948, 991, 993, 994, 1040, 1046, 1055, 1062

979. ATWATER, V. **Energy conservation—hospital engineering services.** *Hospital Engineering*, London, 1979, Mar., vol. 33, no. 2, pp. 5-8.

The sources of energy are examined briefly. Steps taken to reduce energy consumption in one United States hospital included: lowering boiler pressures; replacing incandescent lighting fixtures with fluorescent; reducing lighting levels while remaining within current standards; a power management programme; a window changing programme; and a preventive maintenance programme. A formula for judging the results of energy conservation is presented: energy consumption measure $=$

$$\frac{\text{total BTUs consumed monthly}}{\text{hospital square metres} \times \text{days in month} \times \text{total degree days in a month.}}$$

980. FRIEDMAN, B. **On the rationing of health services and resource availability.** *Journal of Human Resources, Education, Manpower and Welfare Policies*, Madison, 1978, vol. 13, supplement pp. 56-75.

There is a public policy trend in the United States to attempt to limit resources and expenditure for personal health care. Government controls on availability of physicians and hospital resources can counteract some undesired aggregate consequences of reimbursement insurance. Given aggregate controls, many important questions arise concerning non-price rationing of services by physicians. A theoretical model of rationing should be consistent with existing items of evidence on delays, disequilibrium, and 'availability effects'. The model discussed in this paper has a foundation in the mutual advantages of a long-term association between an individual client and physician; these advantages motivate an implicit contract for rationing with a variety of testable implications.

981. GAVETT, J. W. and SMITH, D. B. **A comparison of the hospital cost experience of three competing HMOs.** *Inquiry*, Chicago, 1978, Dec., vol. 15, no. 4, pp. 327-335.

Rochester, N.Y., has three different types of health maintenance organizations (HMOs) offering a unique opportunity to compare their experience with hospital costs—the key determinant of the effectiveness of the HMO cost containment strategy. Five factors directly affect the hospital cost experience of a plan: (i) hospital service mix used; (ii) admission rate; (iii) hospital mix used; (iv) length of stay; and (v) intensity of resources used within a particular hospital service. The relative impact of each of these factors on the hospital cost experience of each plan is presented. The results are presented in five tables and discussed. On the whole, none of the plans experienced the degree of hospital cost savings that have been generally attributed to HMOs. It is concluded that there are a good deal more subtleties involved in assessing the hospital cost control potential of HMOs than is often suggested by their advocates.

BED OCCUPANCY, ECONOMIC USE OF BEDS

See also Abstract Nos. 1071-1073

982. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. **In-patient arrangements: pooling of beds.** (Notes on Good Practices No. 8) London, Her Majesty's Stationery Office, 1978, [8]pp. £0.35

A feature of the new District General Hospitals Units of the Wessex Regional Health Authority at Southampton and Basingstoke, was the introduction of 120-bedded clinical nursing units. One of the operational policies adopted for these hospitals to ensure that bed occupancy is kept at the highest possible level was that there should be 'pooling' of beds—beds would not be allocated to specific consultants and patients of either sex would be admitted. The Regional Health Authority arranged for research to be carried out in order to predict the effect of 'pooling' on bed occupancy before putting the system into practice. This Note summarizes the research.

983. HORNE, J. M. and BECK, R. G. **Temporal patterns in the use of health services leading to cholecystectomy: a process evaluation using insurance records.** *Medical Care*, Philadelphia, 1978, Dec., vol. 16, no. 12, pp. 1006-1018.

Data from Saskatchewan's public medical and hospital insurance programmes are used to estimate a multivariate model of health services use among cholecystectomy patients. A methodology is developed which divides the care process into an assessment period, a waiting period, and a hospital period. The general hypothesis that pre-surgical and surgical decisions of physicians are influenced by extra-medical factors, including the social condition of the patient and the availability of health resources, is only weakly supported by the data.

ELECTRONIC DATA PROCESSING

See also Abstract Nos. 945, 946, 987, 999, 1006, 1031, 1081

984. HAASE, H. **A computer system with central support for multiple use in general hospitals of varying sizes.** *Methods of Information in Medicine*, Stuttgart, 1979, Jan., vol. 18, no. 1, pp. 1-5.

An electronic data processing system in use in general hospitals of various sizes in the Federal Republic of Germany is described. The system can deal with patient admissions, administration and laboratory services and the software is supplied by the Kirchliche Gemeinschafts-stelle für EDV (KIGST). It is thus independent of the hardware suppliers and can be run on many computer systems produced by different manufacturers. The operation of the software system on one particular computer is described. Some administrative and accounting functions are handled by a number of external data processing centres. The five hospitals at present using the KIGST system are named.

985. LEITGEB, H. Maschinenlesbare Belege im Krankenhaus. **[Machine readable records in the hospital.]** *Österreichische Krankenhaus-Zeitung*, Wien, 1979, Jan., vol. 20, no. 1, pp. 9-10, 12-16.

Details are given of the techniques and organization of machine readable record

systems. The conclusion is that on-line data recording equipment (e.g. screen terminals) at every point where data are collected is at present too costly. In the Salzburg Province Hospital machine readable records have been shown to be a suitable and economical alternative.

986. ENGEL, J. M., WENTE, K. W. and STRÖBEL, G. EDV im medizinischen Labor. **[Electronic data processing in the medical laboratory.]** *Krankenhausarzt*, Karlsruhe, 1979, Mar., vol. 52, no. 3, pp. 235-236, 241-242, 244, 247.

The author describes the computer-based system for processing laboratory data adopted at the Baden-Baden State Hospital for Rheumatism. Details are given of the equipment used, of the work flow system and of the problems experienced.

ORGANIZATION AND METHODS, WORK STUDY

See Abstract No. 1078

MEDICAL RECORDS

See also Abstract No. 985

987. HUESING, S. **Computers and the health care industry.** *Dimensions in Health Service*, Ottawa, 1979, Feb., vol. 56, no. 2, pp. 22, 24-26.

The prospect of computers in health services is outlined. The need for communication among those interested in health care computing led to the founding in 1975 of the Canadian Organization for the Advancement of Computers in Health (COACH). The activities of COACH are outlined. Particular attention is given to its attitude towards security and confidentiality and its code of practice on physical security is reproduced. A task force is now being set up to prepare recommendations on legislation.

HOSPITAL ACCREDITATION AND SIMILAR SCHEMES

988. ROSENDAAL, A. T. T. De procedure tot erkenning van ziekenhuizen. **[Hospital registration procedure (in the Netherlands).]** *Ziekenhuis*, Utrecht, 1979, Feb. 21, vol. 9, no. 4, pp. 97-101.

In October 1977 the Dutch government laid down norms required for hospital registration. They were designed as a general framework leaving much flexibility for individual hospitals to act within their financial means. Registration can be refused or withdrawn and only registered hospitals can claim patients' fees from insurance companies. The general norms deal with descriptions of types of hospital, their organization and management, statutes, hygiene, safety etc. The specific norms concern

special functions such as buildings, equipment and insurance. During 1978, at Government request, the NZR (National Hospital Council) tested the impact of these norms in practice. It was found that their interpretation was practically and legally far too flexible. An analysis of the procedure for registration consequently showed that registrations are at present still provisional. The decision lies entirely with the Minister of Health after advice from the NZR, which acts in co-operation with the Council of Health Insurance Companies, and from the inspectors and civil servants of State supervisory bodies. The author would like to see much more clearly defined norms which cannot be interpreted in different ways by different bodies. He would also like to see changes in the information procedure whereby hospitals are informed of the reasons why they are not allowed to register and can appeal against the decision.

989. DANSK SYGEHUS INSTITUT. Sygehustypiske normer 1978. **[Hospital standards.]** (Katalog 78.05) København, Dansk Sygehus Institut, 1978, 115pp. Kr. 55

This catalogue is a complete survey of over 1,400 national and international standards, codes of practice and recommendations which are typical of hospitals and the health sector in general. There are four sections: (i) register of standard institutions; (ii) standards listed according to subject matter; (iii) standards listed according to standard institution; and (iv) subject list of standards. National norms are collected from Denmark, Norway, Sweden, West Germany and the United Kingdom, and selected norms are included from the U.S.A., Canada and other countries, representing the standards that are most used and recognized in Denmark.

LEGAL ASPECTS OF HOSPITAL ADMINISTRATION

See also Abstract Nos. 989, 995, 1022, 1074, 1075

990. JACOBSEN, H. Ansvarsrisikoen ved sygehusdrift og de forsikringsmässige muligheder. **[Hospital liability risks and insurance possibilities.]** *Tidsskrift for danske Sygehuse*, Glostrup, 1979, Feb., vol. 55, no. 2, pp. 16-19.

In addition to its responsibility for the injurious results of treatment causing damage to a third party or property, the hospital is also responsible for insuring adequately all buildings and equipment. Under 'property', the hospital must insure its buildings and their contents, including vehicles, against fire. Hospital proprietors (the State and counties) are not obliged by law to insure staff but are obliged to compensate any staff injured at work, and to report all injuries to the Factory Inspectorate. No special legislation covers injury caused to staff, patients or third parties by the operation of the hospital; responsibility for damages is covered by normal legislation. The hospital may be held liable to compensate patients for injuries caused by negligent operation of equipment by staff. Claims for damages to patients are usually settled out of court: the body of legal experience (court cases and awards of damages) in this area is very limited. Claims for loss of personal belongings against hospitals are very frequent, but the sums involved are trivial. In addition to normal (delictum) responsibility, the hospital may be liable for damages for faulty or negligent use of equipment (product responsibility).

FINANCE AND ACCOUNTING

FINANCE

See Abstract No. 990

COSTS

See also Abstract No. 1046

991. PAULY, M. V. **Medical staff characteristics and hospital costs.** *Journal of Human Resources, Education, Manpower and Welfare Policies*, Madison, 1978, vol. 13, supplement pp. 77-111.

In order to test the hypothesis that medical staff affect hospital behaviour, this paper relates cost data for a sample of non-major teaching, short-stay hospitals to information on the characteristics of the medical staff who treat patients in those hospitals. It is concluded that both the number and the composition of medical staffs affect hospital costs in important ways. The more medical staff there are and the smaller the fraction of total patients for which the average physician cares, the higher will be total costs. Diffusion of output among physicians, such as could accompany mergers, sharing of services, or closing or consolidation of hospitals, tends to be strongly cost-increasing. If a large share of patients are cared for by physicians with only a few admissions to the hospital per month, cost is likely to be high. Further investigation of the processes by which hospitals co-ordinate or organize their medical staffs in order to deal with these influences and the relationships of the organizational processes to costs would appear to be warranted. Holding casemix constant, the specialty composition of the medical staff increases costs. The precise mechanism by which influence occurs is also unclear and further investigation is desirable.

HEALTH INSURANCE

See also Abstract No. 990

992. OKADA, L. M. and WAN, T. T. H. **Medicaid, Medicare, and private health insurance coverage in five urban low-income areas.** *Inquiry*, Chicago, 1978, Dec., vol. 15, no. 4, pp. 336-344.

This paper examines public and private health insurance coverage in five urban, low-income areas of the United States. The data show that third-party financing mechanisms for health care operating in a community can leave a large residue of the population without any kind of health insurance protection. Insurance protection of the elderly was fairly complete, but among other age groups, large segments of the population least able to pay for health care had no insurance.

993. HSIAO, W. **Public versus private administration of health insurance: a study in relative economic efficiency.** *Inquiry*, Chicago, 1978, Dec., vol. 15, no. 4, pp. 379-387.

The major purpose of this study was to make an objective determination of which type of administration can most efficiently perform the intermediary duties of a health

insurance plan. The average cost per unit of output was used as the measure of economic efficiency. The plans chosen for comparison were the Medicare scheme and a large privately insured group, the Federal Employees Health Benefit Program. In both years analysed in the study (1971 and 1972), unit costs were consistently higher under public administration than under private administration. This could be misleading because the functions performed are not exactly alike; when these differences are eliminated, the gap between public and private administration narrows somewhat. Four plausible explanations for the greater efficiency of private organizations are suggested: (i) the element of competition; (ii) the relatively higher salaries of federal employees; (iii) different incentive mechanisms; and (iv) more complex cost control measures in the public programme.

994. TSENG, K. **Administrative costs of Medicare contractors: Blue Cross plans versus commercial intermediaries.** *Inquiry*, Chicago, 1978, Dec., vol. 15, no. 4, pp. 371-378.

This paper compares the administrative costs of Blue Cross and commercial Medicare contractors using four measures: (i) net administrative costs per bill; (ii) claims-related costs per bill; (iii) service-related costs per bill; and (iv) provider audit and reimbursement costs per provider. It was found that during the fiscal year 1976 the Blue Cross plans had significantly lower costs by all measures except provider audit and reimbursement cost per provider. It was also found that both Blue Cross and commercial insurers experienced economies of scale in Medicare administration.

995. COOPER, J. K. **No-fault malpractice insurance: Swedish plan shows us the way.** *Hospitals*, Chicago, 1978, Dec. 16, vol. 52, no. 24, pp. 115, 116, 118, 120.

The Patient Injury Insurance Plan began to operate in Sweden in January 1975 As a group, the county councils, who individually operate nearly all hospitals, purchased an insurance policy that would not only cover their liability due to negligence, but would also provide compensation for patients. The operation of the plan is outlined and its claims experience is compared with that of the traditional liability system of the United States. The author believes that an insurance system similar to the Swedish plan could work in the United States, but only if certain conditions are created: (i) the insurance plan must be exclusive; (ii) binding arbitration should be used to settle disputes; (iii) recovery through the insurance plan should be for 'net' losses only; and (iv) payment of large awards should be made on an instalment basis rather than as a lump sum.

SUPPLIES AND STORES

PURCHASING

996. HOUSLEY, C. **Simplifying the purchasing process.** *Dimensions in Health Service*, Ottawa, 1979, Jan., vol. 56, no. 1, pp. 36-37.

The process of requisitioning and ordering supplies in a hospital can be simplified if the requisition form and the purchase order form are one and the same document. An efficient way of operating such a system is the P.A.R.D. (purchasing-accounting-

receiving-data processing) method which is recommended by the author. The system is built round a facsimile copier and a single order form, one copy of which is transmitted to the supplier. Its operation in the ordering, supply, receipt of and payment for goods is described. The single copy requisition-purchase order form, if properly used, makes typing orders unnecessary, duplication of paper is avoided, and the copier is generally paid for by the supplier—three factors which made the system not only simple but inexpensive too.

STORES

997. CLINKSCALES, W. D. S. **Planning a centralized hospital supply service for a developing country.** *Hospital Engineering*, London, 1979, Mar., vol. 33, no. 2, pp. 8-12, 14-15.

The health service of the Transkei has 31 hospitals with a total of 6,457 beds, together with a number of clinics distributed throughout the country which has a total area of 41,620 sq. kms. In the past, each separate hospital was responsible for the procurement and delivery of all supplies, though certain items could be purchased from a central store in Pretoria. A survey team, appointed when the country became independent, found that the services suitable for centralization were laundry, catering (partial), sterile supplies, pharmaceuticals, and medical equipment maintenance. Details of the recommendations on each service are given, together with proposals on transport and an estimate of cost.

CATERING, DIETETICS, KITCHENS

HOSPITAL CATERING

See also Abstract No. 1000

998. PESKETT, E. J. **Hospitals for the mentally ill and handicapped in Melbourne, Australia.** *Journal of Human Nutrition*, London, 1979, Feb., vol. 33, no. 1, pp. 70-74.

The author studies patterns of nutrition in Melbourne, Australia in (i) psychiatric units in general hospitals; (ii) day-training or rehabilitation centres; and (iii) older, long-stay institutions. The psychiatric units shared the choice of menu system with the rest of the hospital. In the older hospitals, the distance between the kitchen and the wards caused food transport problems and meal times were often staggered. Problems arising from the shortening of catering staff hours were sometimes overcome by the provision of a plated frozen meal service. The quality of the catering staff varied considerably, but in one centre courses were run for cooks employed by the Mental Health Authority of Victoria. In 1977 there was one consultant dietitian for all the mental health establishments in Melbourne, who was more involved in management than in patient care. Modern trends in the mental health service include plans to increase shared services and facilities between general and psychiatric hospitals, and greater emphasis is being placed on the prevention of certain types of mental illness and handicap.

999. HART, P. E. **Computerized systems cut dietary department's costs.** *Hospitals*, Chicago, 1978, Dec. 16, vol. 52, no. 24, pp. 123-124, 126.

The 985-bed University of Cleveland Hospital provides almost 8,000 patient and cafeteria meals on the busiest days. By applying effective computer systems to all phases of catering, the hospital has substantially reduced its food and labour costs. The total system consists of three parts: inventory management, recipe standardization, and ingredient control. The system is based on three master files: inventory, listing all food and supply items, their yield and costs; menu, listing menu items, correlating with a recipe on the recipe file and listing a forecast of need; and recipe, listing all menu items and correlating each ingredient with the appropriate one in the inventory file. Other ways in which savings were accomplished are listed.

DIETETICS IN THE HOSPITAL

See also Abstract No. 998

1000. Normalisatie van diëten in academische ziekenhuizen. **[Standardization of diets in teaching hospitals.]** *Ziekenhuis*, Utrecht, 1979, Jan. 24, no. 2, pp. 36-37.

A working group, which includes the principal dietitians of teaching hospitals, has worked out new definitions for the standardization of diets. The term 'diet'—a dietary regime which for medical reasons diverges from the normal regime', is considered to be the most important point in the classification. The divergencies are divided into groups with certain characteristics. The first group consists of main characteristics. These are directly connected with the clinical picture and relate to nutrients, non-nutrients and consistency. Nutrients and non-nutrients are grouped according to their actions of restriction, enrichment, elimination and substitution. The aims of the main characteristics can be symptomatic, therapeutic, diagnostic, curative therapeutic, or for research. The second group consists of added characteristics. These are also connected with the clinical picture but as a requirement for the diet to achieve optimal therapy. They relate to temperature, frequency, method of administration, sterility, and digestibility. A single diet diverges only in one main characteristic from a normal regime, a complex diet in two or more. The term light diet is rather empirical and its acceptance depends on the individual patient.

LAUNDRIES AND LINEN SERVICE

LAUNDRIES

1001. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. **Linen services: home laundry service.** (Notes on Good Practices No. 10) London, Her Majesty's Stationery Office, 1978, [4]pp. £0.30

The Management Services Unit of Northamptonshire Area Health Authority devised an operational policy for controlling the home laundry service in Northamptonshire. The requirements of the scheme were to: (i) allow for an adequate supply of

clean linen to each patient; and (ii) ensure that there was adequate control over stocks of linen. The procedures involved in the development of the home laundry service are described. The service has been of help to both the nurses and relatives of sick people who are being nursed in their own homes.

HOSPITAL DOMESTIC MANAGEMENT

DOMESTIC WORK

1002. TYCHE, A.-L. Hur skall vi organisera städfunktionen i framtiden? **[How shall we organize cleaning services in the future?]** *Sjukhuset*, Göteborg, 1979, vol. 56, no. 2, pp. 76-77.

Spri, the Swedish Hospitals Rationalization Board, held a conference with 200 participants on the theme of the organization of hospital cleaning services in the 1980s. From the point of view of hospital hygiene, it is immaterial who does the cleaning, provided it is done properly. Present trends seem to be moving away from employing specialists for cleaning and returning responsibility to ward staff, with the aims of increasing patient-to-staff contact and spreading the burden of unattractive working hours over a larger number of employees.

HYGIENE IN THE HOSPITAL

HOSPITAL INFECTIONS

See also Abstract Nos. 1010, 1058, 1059

1003. FREEMAN, J. and MCGOWAN, J. E. **Risk factors for nosocomial infection.** *Journal of Infectious Diseases*, Chicago, 1978, Dec., vol. 138, no. 6, pp. 811-819.

Studies of hospital infection are difficult to evaluate because of differences in the relative susceptibility of patients, the use of different methods of surveillance, and the frequent failure to distinguish between measurements of incidence and of prevalence. The purpose of the study was to make a systematic survey of risk factors for hospital infection in a large general hospital. The data obtained indicate that it is feasible to calculate the relative risk of hospital infection for each patient, supplemented with other generally available information. The risk of infection must be calculated per day rather than per admission to separate the effect of long-stay from the effect of high daily risk. Certain underlying diseases, procedures, hospital services, and categories of age, sex, race, and urgency of admission were all found to be significant risk factors for hospital infection.

1004. TAYLOR, A. G. and others. **Infection of total hip prostheses by *Peptococcus magnus*: an immunofluorescence and ELISA study of two cases.** *Journal of Clinical Pathology*, London, 1979, Jan., vol. 32, no. 1, pp. 61-65.

In two cases of infected total hip replacements *Peptococcus magnus* was isolated in pure culture from the implant when it was removed. Fluorescent antibody and ELISA

studies have shown that both patients developed an antibody response to this anaerobic coccus soon after the replacement operation. These results suggest that the organism is a true infective agent, which was probably responsible for the failure of the arthroplasty operation.

1005. SEEBERG, S. and SVEDHEM, A. Stafylokocker och stafylokockinfektioner. **[Staphylococci and staphylococcal infections.]** *Sjukhuset*, Göteborg, 1979, vol. 56, no. 2, pp. 80-81.

Most skin and wound infections are caused by *Staphylococcus aureus*, a normal constituent of the human epidermal and nasal flora. The only method of spread of importance is direct contact. Hospital staff suffering from some staphylococcal infection such as a boil comprise a greater risk to hygiene than a bed-ridden infected patient. Patients with open wounds with copious secretion must be kept isolated; protective gloves and outer clothing must be worn for visiting and touching the patients, and the strictest hygiene must be observed. There seems to be no statistically significantly increased risk of staff becoming infected by staphylococcal infection from patients: those who do become infected normally heal quickly. There is an increased risk of staphylococcal infection in cases of: (i) open wounds; (ii) skin conditions such as exczema; (iii) in-dwelling foreign bodies; (iv) reduced body defenses; (v) reduced powers of recuperation as in diabetes; and (vi) certain types of cancer. Treatment is not difficult and isoxacilline is available for combatting penicillin-resistant strains. Phage typing is a useful technique for following the course of spread of an infection and in the normal epidemiological surveillance of hygiene in the hospital.

1006. KELLY, J., ROBERTS, J. and HARVEY, P. W. **A simple data-processing system for the monitoring of cross-infection in a district general hospital.** *Medical Informatics*, London, 1979, Jan./Mar., vol. 4, no. 1, pp. 29-34.

This paper reports a one-year trial of a simple data processing system for the early identification of hospital infection problems at their source. All bacteriology report forms originating from two general surgical wards (one male and one female) at the Royal Lancaster Infirmary which reported any growth of organisms were routinely photocopied. The photocopies were coded by the cross infection officer. The coded data was transmitted via a Post Office line, from the computer section of the pathology laboratory to the regional health authority laboratory 50 miles away. Weekly reports on positive organisms were displayed in the surgical unit and after one month each report was filed but was still readily available. Monitoring of operating theatres was carried out monthly or when requested. A standard series of swabs were taken from specified sites and a slit sampler was run for 30 minutes after a full day of operating. This information was recorded in a special register and was not included in the computer analysis. The system proved to be effective and has particular advantages for small and scattered surgical units. A simple extension of the scheme could audit the efficiency of preventive antiseptic measures, particularly aseptic techniques, and provide antibiotic profiles.

1007. CZARLINSKY, D. K. and others. **Staphylococcal colonization in a newborn nursery, 1971-1976.** *American Journal of Epidemiology*, Baltimore, 1979, Feb., vol. 109, no. 2, pp. 218-225.

During the six-year period 1971 to 1976, 9,515 infants were admitted to the nursery

of Children's Mercy Hospital, Kansas City, Montana. The mean colonization rate by *Staphylococcus aureus* from 1971 to 1974 was 14 per cent. Analysis of variance of data for this period revealed no significant change in colonization rates following discontinuation of hexachlorophene bathing of infants in January 1972. Also there were no consistent phage types present nor changes in the number of phage typable staphylococci during the period. During 1975 and 1976, *St. aureus* phage type 95 became epidemic and accounted for 74 per cent of colonization by *St. aureus;* this was accompanied by a significant increase in colonization rates in 1975 and 1976 (29 and 25 per cent respectively). Cultures of the anterior nares of mothers and nurses, the umbilical cords of infants and fomites within the nursery eliminated these as sources. The primary reservoir was apparently the infants themselves and the postulated mode of transmission was hand carriage. The origin of the organism in the infant population was not determined. Triple dye or bacitracin ointment applied to the umbilical cord was effective in reducing colonization.

1008. DAVIS, J. P. and others. **Nasal colonization of infants with group B *Streptococcus* associated with intrauterine pressure transducers.** *Journal of Infectious Diseases*, Chicago, 1978, Dec., vol. 138, no. 6, pp. 804-810.

The rate of nasal colonization with group B *Streptococcus* in infants cultured at the time of discharge from the nursery at Duke University Medical Center, Durham, N.C., rose significantly during a four-month period. Investigation resulted in the detection of group B streptococci in the domes of two intrauterine pressure transducers (IPTs). Subsequent routine sterilization of IPT domes after each maternal use brought colonization down to the usual endemic rate in the nursery. Retrospective evaluation showed that colonization in infants born to IPT-monitored women had increased significantly during the study period and that no increase in colonization occurred in infants born to non-IPT monitored women. From epidemiological evidence it appears that use of contaminated IPTs during labour was a hospital source of group B streptococcal colonization.

1009. HALL, C. B. and others. **Neonatal respiratory syncytial virus infection.** *New England Journal of Medicine*, Boston, 1979, Feb. 22, vol. 300, no. 8, pp. 393-396.

Respiratory syncytial virus infections are thought to be uncommon in the first month of life. During an outbreak in the community, the possible presence of the infection was studied in the neonatal units at the University of Rochester Medical Center, New York. Of 82 neonates studied, 66 were in hospital for six days or longer. Twenty-three of these acquired the virus, 20 being under one month in age. Infected babies had had a shorter gestation period and a lower birth weight. The illness was often mild, especially in infants under three weeks who had less respiratory tract involvement and lower quantities of virus in their noses. Infection was also acquired by 34 per cent of the staff, who were a significant factor in the spread of the virus. The findings suggest that respiratory syncytial virus may readily infect neonates, but the disease is often mild or untypical and may be overlooked.

SOURCES OF INFECTION

See Abstract Nos. 1008, 1011

PREVENTION AND CONTROL

See also Abstract Nos. 1004, 1006, 1009, 1015, 1036

1010. THOMAS, M. **The role of the microbiologist.** *NATNews*, Matlock, 1979, Feb., vol. 16, no. 2, pp. 6-8.

The role of the microbiologist is discussed with particular reference to: costs and safety; the incidence of hospital infection; environment surveillance; process control; transmission of infection; disinfection; admissions; and staff health. The medical microbiologist has a traditional primary responsibility for the accurate identification of microbial agents of disease. Increased recognition of the importance of hospital-acquired infection has brought an additional responsibility for the organization of an infection control service. In relation to other hospital staff, the role of the microbiologist is informative, advisory and supportive.

1011. FADEN, H. and MCLAUGHLIN, S. **Gentamicin-resistant *Staphylococcus aureus:* emergence in an intensive care nursery.** *Journal of the American Medical Association*, Chicago, 1979, Jan. 12, vol. 241, no. 2, pp. 143-145.

Strains of gentamicin-resistant *Staphylococcus aureus* suddenly appeared in an intensive care nursery at the Children's Hospital, Buffalo, New York, in December 1976. By April 1977 such strains accounted for 96 per cent of all the isolates recovered from many body sites. All the gentamicin-resistant strains were sensitive to amikacin, and all but one to methicillin sodium, but 98 per cent were resistant to kanamycin and 49 per cent to tobramycin. Phage-typing of gentamicin-resistant strains showed that most shared a susceptibility to two specific phages, but 13 per cent were completely different, indicating that gentamicin resistance is not solely related to any particular phages. The frequent occurrence of gentamicin-resistant *Staphylococcus aureus* in the intensive care nursery may have been related to the widespread use of gentamicin in that unit.

HYGIENE IN THE OPERATING THEATRE

See Abstract No. 1012

STERILIZATION

See Abstract No. 1032

AIR HYGIENE

1012. Te hoge narcose gascocentraties in OK's: alleen met meerpunts-meetmethode wordt exact beeld gegeven: Miran analyzer voor maken van 'concentratielandkaart'. **[Excessive anaesthetic gas concentrations in operating theatres: an exact picture can only be provided by using multiple point measuring methods: the Miran analyzer provides a (three dimensional) 'concentration map'.]** *Technische gids voor ziekenhuis en instelling*, Amsterdam, 1979, Jan., vol. 48, no. 1144, pp. 8-11.

To ensure a safe level of anaesthetic gas concentrations in operating theatres (to

avoid risk of tumours, genetic effects and reduced performance by staff) measurements should be taken at several points, as concentrations vary in different areas (the highest being near the anaesthetist). To this purpose the 'Miran IA Gas Analyser' was developed. This is a measuring instrument consisting of a one point recorder, an amplifier, gas reception cell, infra-red spectro-photometer and a suction tube with a filter. During an operation the filter can be placed anywhere in the theatre so that at a number of continuing points the concentration of the gases can be measured and instantly recorded, thus providing a three-dimensional map from which the highest concentration can be easily and quickly read. These data, together with the air current pattern of the existing ventilation system, give a clear picture of where to introduce changes. Some other details are given, including the mixtures and concentrations of gases (laughing gas and halothane) at levels recommended in international agreements and the workings of the spectrophotometer using the fairly new technique of infra-red spectroscopy which determines the presence of gases from their infra-red spectrum. Two reports are given of measurements taken in two unnamed hospitals. In both the concentration levels were found too high and the working of their gas absorption charcoal filters unsatisfactory. An international connection unit for various anaesthetic gas bottles is recommended. The paper includes six pictures and two graphs.

1013. HAMM, G. and others. Halothan-Arbeitsplatzkonzentrationen in Operationssälen des Bezirkes Magdeburg. **[Halothane concentrations in operating rooms in medical facilities in the County of Magdeburg.]** *Zeitschrift für die gesamte Hygiene und ihre Grenzgebiete*, Berlin, 1979, Jan., vol. 25, no. 1, pp. 14-18.

A group of industrial toxicologists has studied the effects of exposure to halothane and other gases, as well as to increased concentrations of carbon dioxide, on 700 operating theatre staff in 43 hospitals in the Magdeburg area. Only in 10 of the theatres was the summation quotient less than one. Peak concentrations of up to 1,557 mg/cu.m halothane were measured in the case of breathing mask anaesthesia, 279 mg/cu.m. in semi-closed systems, and 114 mg/cu.m. in intubation anaesthesia in semi-open and 11 mg/cu.m. in semi-closed systems. Halothane concentrations of between 0.010 and 0.017 mg/ml were measured in the blood of theatre staff; and concentrations of between 0.004 and 0.0011 mg/l air were found in their exhaled air after operations had taken place.

1014. MALE, C. G. **Theatre ventilation: a comparison of design and observed values.** *British Journal of Anaesthesia*, London, 1978, Dec., vol. 50, no. 12, pp. 1257-1263.

The ventilation rates of 23 plenum-ventilated operating theatres in four city hospitals were tested at random. One modern operating theatre was studied in detail over six months and the causes of poor ventilation were determined. The method of measurement is described and detailed results given. Ventilation rates in all 23 theatres varied widely from the design specifications, the overall performance being 15 per cent less than in the specification. Results showed that preventative maintenance schemes improved plant performance. Efficient theatre ventilation reduces contamination from anaesthetic gases and removes airborne bacteria. The system should also maintain a temperature in the range of 21°C to 24°C and 55 per cent relative humidity.

1015. DUVLIS, Z. Luftkeimzahlen im Operationsraum. **[Airborne germ count in operating theatres.]** *Das Öffentliche Gesundheitswesen*, Stuttgart, 1979, Jan., vol. 41, no. 1, pp. 13-16.

A formula has been developed for demonstrating the relationship between the concentration of airborne micro-organisms in theatres during operations, the number of persons present, the air change rate per hour and the room volume. The formula is:

$$a_t = a_o \cdot \frac{z(1+\frac{1}{x}[1-(\frac{1}{x})^t]}{1-\frac{1}{x}} \qquad X = 1 + \frac{Uw}{12}$$

where a_o = germ count per person and per five minutes; a_t = germ count at the time '$_t$'; t = time in five minute intervals; Uw = changes per hour; and z = number of persons present. The formula can be used for testing the efficiency of air-conditioning systems in operating theatres and in their construction. Examples are given.

SAFETY MEASURES

See Abstract Nos. 948, 1037

ACCIDENTS, GENERALLY

See also Abstract Nos. 1038, 1060

1016. JOHANSSON, A. Förväntningar på skyddsombudet:—varför har du inte satt upp liften ännu? **[Expectations in hospital safety representation work: why have you not installed patient lifting equipment yet?]** *Vårdfacket*, Stockholm, 1979, Jan. 11, vol. 3, no. 1, pp. 4-7.

Under the Workers' Protection Act of 1912, places of work have a safety representative, whose powers are nowadays quite wide. The employer is responsible for assisting the safety representative (appointed by the trade union) in the campaign for satisfactory working conditions. Hospital safety representatives complain that they have to fight for every piece of information which is due to them, e.g. lists of harmful fluids at the place of employment, or results of measurements of concentrations of gases in the air. The safety representative also sits on the safety committee, which is obligatory in all institutions with over 50 permanent employees. It was decided in 1978 that lifting equipment should be installed at Sabbatsberg Hospital, Stockholm to transfer surgical patients from the trolleys into the beds which were lower in height. The money needed (s.kr.30,000) was available on an account containing s.kr.80,000 for environmental improvements measures. However, the grant was refused since a lift is not considered to be an environmental question. By chance, the ward sister happened to speak to someone in charge of another fund, and the equipment was installed after months of delay. In general, doctors do not show any interest in environmental questions. The safety representative also needs more powers to enforce improvements in areas found unsatisfactory, such as leaking anaesthetic gases, wrongly installed taps or dangerous slippery floors.

FIRES AND FIRE PREVENTION

1017. VOLZ, S. Brände verhüten ist besser als bekämpfen. **[It is better to prevent than to fight a fire.]** *Deutsche Krankenpflege-Zeitschrift*, Stuttgart, 1979, Feb., vol. 32, no. 2, pp. 77-82.

It has been demonstrated that more hospital fires have been caused by careless smokers than by any other single factor. The most vulnerable areas are: rooms where waste material is stored; laboratories; laundries; and rooms rarely used. A series of nine photographs highlights possible risks. The most important measures for the prevention of fires in hospitals are briefly detailed.

1018. BENJAMIN, I. A. **A fire safety evaluation system for health care facilities.** *Fire Journal*, Boston, 1979, Mar., vol. 73, no. 2, pp. 52-55, 95-96.

This paper describes the development by the United States National Bureau of Standards of a method of evaluating health care facilities to determine what fire safety measures would provide a level of safety equivalent to that provided by the National Fire Protection Association's *Life safety code*. Each zone (that is the area on a floor between smoke barriers) must be individually evaluated. The procedure is: (i) evaluate the risk to the zone from the product of the risk factors (patient mobility, patient density, fire zone location, ratio of patients to attendants, and patient average age); (ii) evaluate the general safety for the zone by adding the value of 13 components of building construction to determine if the safety is equal to or greater than the risk; (iii) evaluate the safety of each of the subsystems (containment safety, extinguishment safety, people movement safety, and general safety) by adding up the value of the components for that particular subsystem and comparing them to determine whether or not the subsystem exceeds the stipulated value in the regulations; and (iv) if the building is not up to standard, review the design and construction of the building to determine which safety components may be most economically added or upgraded to bring it to the required level.

THE PATIENT

ADMISSION AND RECEPTION

See Abstract No. 1045

WELFARE OF THE PATIENT

See also Abstract Nos. 935, 971, 1052, 1056, 1082

1019. SZEKELY, A. Die information im Krankenhaus. **[Information in the hospital.]** *Hospitalis*, Zurich, 1979, Feb., vol. 49, no. 2, pp. 91, 93, 94, 97.

The author discusses a number of problems related to the important subject of informing the patient. The basic fact is that the patient has a right to information;

under certain circumstances he also has the obligation to take notice of this information. The following points are discussed: what should be said by the hospital; how much information should he be given; what information is necessary, what is harmful and what is useful; when should the dying patient be told of his condition; how do we inform the dying patient; whose task is it to give the information; and when is it necessary to inform the dying patient. Some of the difficulties dealt with are the lack of time and lack of training in communication of doctors and other hospital staff.

1020. ROYAL COMMISSION ON THE NATIONAL HEALTH SERVICE. **Patients' attitudes to the hospital service,** by Janet Gregory, (Research Paper No. 5) London, Her Majesty's Stationery Office, 1978, x, 257pp. £4.00

The aim of this survey was to find out about people's experiences of, and attitudes towards the hospital service provided by the National Health Service. Both the views of out-patients and of in-patients were to be considered. The study was first commissioned in April 1977, a small pilot and feasibility study was carried out in July 1977, and the interviews for the main stage survey were conducted between November 1977 and January 1978. The report is in 13 sections and covers: the survey design and background; the characteristics of the sample; waiting times for admission to hospital, or for a first out-patient appointment; getting to hospital; facilities provided for patients; the hospital ward or room; its comfort and the daily routine; out-patient appointments and waiting to see the doctor; privacy; communication; relationship between patients and hospital staff; discharge from hospital; and dissatisfaction with the service. Three appendices include: details of the sample design and response; trailer questions, postal questionnaire, in-patient and out-patient questionnaires; and supplementary tables.

1021. TROSCHKE, J. von and JÜNGER, E. Patienten-Information durch gezielte Rundfunksendungen baut Unsicherheit ab. **[Hospital radio information programmes reduce patients' insecurity.]** *Krankenhaus*, Stuttgart, 1978, Dec., vol. 70, no. 12, pp. 473-477.

In July 1978 an experiment was carried out at the Bremen North Hospital in an attempt to determine the value of special hospital broadcasts explaining hospital organization and procedures to patients. Nineteen different programmes of half an hour each were drawn up and broadcast on successive days at 7 p.m. Patients were asked to fill in questionnaires after each broadcast; some patients filled in questionnaires on discharge; and some were interviewed. Doctors and nurses were also questioned. The results are set out in a series of tables which show, among other things, that: 82 per cent of respondents heard the whole of the broadcast; 77 per cent thought the broadcasts were 'good' or 'very good'; 64.5 per cent had learned a great deal; 54 per cent said that the broadcasts had encouraged them to talk to doctors, and 77.5 per cent said that such programmes should be generally introduced in hospitals. The conclusion is that such broadcasts improve the situation of hospital patients.

1022. BARKES, P. **Bioethics and informed consent in American health care delivery.** *Journal of Advanced Nursing*, Oxford, 1979, Jan., vol. 4, no. 1, pp. 23-38.

The discipline of bioethics attempts to develop in individuals an understanding and appreciation of the knowledge of both the science of living things and of human values. Ethics and informed consent are interrelated issues. Consent is the central issue on

which hang most of the ethical problems in human experimentation. Four major types of consent are considered: implied consent, express consent, written express consent, and consent from a third party. The informed consent of the patient is the ultimate protection from the hazards of research and therapy in medicine. The patient must be given a full prognosis, including complications, sequelae, discomforts, costs, inconveniences, risks and expectations. The patient should be told enough to allow him to make a rational decision. The paper contains an analysis of the reactions of just a few American nurses to this dilemma. The nurse who attempts to use only her scientific training to determine ethical conduct is in a quandary because seldom is there empirical evidence available to support her decision, no matter what it is.

TERMINAL CARE

1023. HINTON, J. **Comparison of places and policies for terminal care.** *Lancet*, London, 1979, Jan. 6, vol. i, pp. 29-32.

A group of 80 terminally ill patients being cared for in an acute hospital ward, a hospice or a home for cancer patients were interviewed. Assessments of patients were expressed as scaled ratings and were accompanied by comments on their emotional state, their attitude to their illness and its outcome and their opinion on the care they were receiving. Comparisons of care were made between matching groups in the different types of institutions. The in-patient opinions of their medical treatment did not differ from one unit to another, but for other aspects of care the patients expressed greatest praise for the hospice. Although there were only marginal differences in communication practice in the three units, hospice patients were less depressed and less troubled about the probable fatal outcome of their illness. However, the acute hospital gave a high level of care which was generally well received by the recipients. As no policy on the care of the dying can be final, new facilities are best planned according to local needs and resources.

HOSPITAL CARE

See also Abstract Nos. 945, 946, 949, 972, 973, 980, 981, 1075-1077, 1083

1024. ABERMETH, H.-D. Organisation einer ganzheitlichen Pflege. **[The organization of total patient care.]** *Deutsche Krankenpflege-Zeitschrift*, Stuttgart, 1979, Feb., vol. 32, no. 2, pp. 68-71.

Total patient care requires full collaboration between doctor and nurse as well as the involvement of the patient himself. An important step is the drawing up of a nursing plan under the following four headings: (i) ascertaining the patient's history in relation to nursing needs; (ii) determining nursing aims, the nursing plan and the prescription plan; (iii) extending the plan and producing the report; and (iv) evaluating results. Each of these is described. A typical nursing plan is reproduced in the paper and an actual example is given.

1025. TEEKEN, V. Ganzheitliche Pflege im Krankenhaus - Möglichkeiten und Grenzen. **[Total nursing care in the hospital: possibilities and limitations.]** *Deutsche Krankenpflege-Zeitschrift*, Stuttgart, 1979, Feb., vol. 32, no. 2, pp. 83-87.

Total patient care can be organized under three systems: (i) the patient's room

system, under which one nurse takes over the full care of one or two patients' rooms; (ii) the group nursing system, under which a small team of nurses looks after between 10 and 20 patients; and (iii) the individual nursing system (used in Germany for intensive care), under which a single nurse takes full charge of a few patients. A table sets out the four stages of nursing quality (0, where the patient suffers no harm; 1, where the patient gets minimal, routine nursing; 2, where the patient is nursed according to his needs; and 3, optimal care; where the patient himself is involved). For each of the four stages the table sets out the main features of nursing care in the following categories: basic care; treatment; mental and social needs; communication; and the nursing plan and provision of information. The advantages and disadvantages of each stage are discussed.

1026. CANTOR, M. M. **Achieving nursing care standards: internal and external.** Wakefield, Mass., Nursing Resources, Inc., 1978, x, 180pp. $12.95

The aim of this book is to help nursing administrators examine nursing care standards—their purposes and their uses in achieving quality of care—and to suggest a method of training that makes standards a natural feature of the organization of nursing departments. Part I provides a basis for examining and developing nursing standards; part II considers standards of patient welfare, and provides material on planning for and evaluating schemes for quality assurance in terms of patient results. Part III considers process standards, performance standards and standards for staff education; part IV considers the issues involved in establishing and evaluating the structure within which nursing care is provided.

1027. KUPST, M. J., SCHULMAN, J. L. and DOWDING, J. **Evaluation: attitudes toward patient care and work satisfaction.** *Hospital & Health Services Administration*, Chicago, 1979, vol. 24, no. 1, pp. 78-92.

The first phase in the development of a human relations programme at Children's Memorial Hospital, Chicago, was the initial assessment of patient and staff needs and attitudes. More than 50 per cent of full-time staff completed a questionnaire composed of two scales: hospital personnel scale and patient care scale. A structured interview was used with a random sample of 150 parents. The results are presented and discussed. A number of problems were found and the means by which some of these were solved are outlined.

DISCHARGE OF PATIENTS

1028. FENWICK, A. M. **An interdisciplinary tool for assessing patients' readiness for discharge in the rehabilitation setting.** *Journal of Advanced Nursing*, Oxford, 1979, Jan., vol. 4, no. 1, pp. 9-21.

This paper describes the development of an interdisciplinary tool to assess the readiness of patients for discharge. The rationale behind the tool is discussed and the literature is reviewed for current perspectives of measurement in rehabilitation, the desirability of planning discharges or referrals, and the interdisciplinary nature of the health care team. The concept of readiness is also discussed. Five categories are used to assess readiness: (i) the patient's medical status of readiness; (ii) the patient's func-

tional readiness; (iii) the patient and family's psycho-social readiness; (iv) the patient's readiness in communication skills; and (v) the patient and family's expressed readiness for future living patterns. The continuum of readiness is divided into five stages: readiness; progress towards readiness; no change in readiness; deterioration of readiness; and non-readiness. Examples of the forms used are reproduced, including some for an actual patient.

HOME CARE, AFTER-CARE

See also Abstract No. 1001

1029. PINDING, M., LOMMATZSCH, E. and WEBER, B. Hauskrankenpflege bei Kindern. Externer Pflegedienst der Kinderklinik der Freien Universität Berlin (KAVH)—Zur Konzeption des "Rooming-out". **[Home care for children. The external service of the Children's Hospital of the Free University of Berlin: the concept of 'rooming-out'.]** *Deutsche Krankenpflege-Zeitschrift*, Stuttgart, 1979, Jan., vol. 32, no. 1, pp. 39-43.

While hospital-based home care services for adults are known, the provision of such a service for children is an innovation, which the Children's Hospital of the Free University of Berlin introduced a year ago. The aim is as far as possible to avoid admitting children to hospital or to reduce the length of stay where admission has been necessary. The project involves close collaboration between: the nurse; doctors; patients' relatives; such professional people as social workers, dietitians, remedial gymnasts and psychologists; and the general practitioners. The advantages of home care include the following: avoidance of the trauma of separation from parents; care in a home environment; and a considerable saving in hospital costs. In the case of chronically sick children the aim is gradually to train and advise parents so that they can eventually care for their children themselves. Experience so far obtained gives encouragement for further development of this concept of 'rooming-out'.

SPECIAL DEPARTMENTS

OPERATING SUITES

See Abstract Nos. 1014, 1015, 1063

ANAESTHESIA

See Abstract Nos. 1012, 1013

MORTUARIES AND POST-MORTEM ROOMS

1030. CAMERON, H. M. **The autopsy: its role in modern hospital practice.** *Investigative & Cell Pathology*, Chichester, 1978, Oct./Dec., vol. 1, no. 4, pp. 297-300.

Although autopsies have decreased in recent years owing to sophisticated clinical forms of diagnosis, they are still valuable both to diagnosis and the needs of research.

In assessing 200 cases retrospectively, the author found disagreement between ante-mortem and post-mortem diagnosis in 39 per cent. In a further 57 per cent, additional factors contributing to the cause of death were found. When patients had been in hospital over a month, autopsy findings altered the diagnosis in over half the cases. Clinical diagnosis cannot always provide an acceptable guide as to whether or not an autopsy is to be performed. If the autopsy is to be used more fully, more logical criteria for selection should be developed. In some cases, autopsies could be more thoroughly carried out, making use of sophisticated techniques when relevant and helpful. More care should be taken by both pathologists and clinicians to produce a final correlation of pathological and clinical data.

PHARMACY

See also Abstract No. 1052

1031. BARNETT, J. W. and others. **The Hereford hospital prescribing study.** *Journal of Clinical Pharmacy*, Oxford, 1978, Dec., vol. 3, no. 4, pp. 235-238.

The use of a West Midlands Regional Health Authority computer enables medical and pharmaceutical staff to carry out research into drug efficacy, prescribing patterns and drug reactions in the hospitals of Hereford. Details of the patient's drug treatment while in hospital, the medicines taken home and any information on drugs taken before admission were collected between 1975 and 1977. Over 22,000 drug records are now available for analysis. Current and projected investigations include: (i) a study of drugs taken before admission; (ii) a study of the accuracy of prescribing patterns and the incidence of adverse drug reactions in hospital; and (iii) a study of the drugs taken on and after discharge and any problems involving adverse reactions or difficulties with compliance. The study is expected to be of interest and benefit to both patients and staff in the Hereford hospitals.

1032. Apotheek en centrale sterilisatie in één. **[A combined pharmacy and central sterilization unit at Deventer Hospitals.]** *Ziekenhuis*, Utrecht, 1979, Feb. 21, vol. 9, no. 4, pp. 80-81.

The paper gives extracts from speeches made at the opening of the unit, a project of the Foundation Pharmacy of the Deventer Hospitals, set up in 1956. The pharmacy at present provides for 730 general, 928 psychiatric and 307 long-term and rehabilitation beds. The original building had a floor area of 650 sq.m. to accommodate a production section and a laboratory, but by 1972, due to expansion and the renovations needed by some hospitals, it was decided to combine the pharmacy with a central sterilization unit for a number of hospitals in one new building. The pharmacy now has a block for production, a block for reception and issue of prescriptions on the ground floor and a laboratory in the basement. Throughout the building process there has been excellent co-operation with the authorities.

1033. SPIGIEL, R. W. and ANDERSON, R. J. **Comprehensive pharmaceutical services in the emergency room.** *American Journal of Hospital Pharmacy*, Washington, D.C., 1979, Jan., vol. 36, no. 1, pp. 52-56.

A decentralized pharmaceutical service functions from 1600 to midnight daily in the emergency room of the University of Nebraska Medical Center. The cost of installing

the system was less than $2,200, including the cost of the mobile medication trolley (illustrated) stocked with a limited inventory of pre-packaged medications. Approximately 94 per cent of the prescriptions originating from the emergency room between 1600 and 0800 can be filled from the trolley. Results of a nine-month survey indicated that an average of 20.6 prescriptions were filled on each 1600 to midnight shift. The income derived from the service more than covered the cost of the drugs and the salary of the pharmacist providing the service.

1034. TOMASCHKO, H. Ökonomische Arzneimittelgebarung im Krankenhaus durch Prüfungsausschuss. **[Economical drugs management in the hospital by means of a reviewing committee.]** *Österreichische Krankenhaus-Zeitung*, Wien, 1979, Jan., vol. 20, no. 1, pp. 19-24.

The hospital drugs reviewing committee is considered to be the best means of ensuring a system of drugs management which is medically acceptable and economic. The medical director, consultants and the pharmacist should be members of the committee. When a doctor wishes to introduce a new drug he makes a short report on it to the medical director: it is then thoroughly investigated by the committee and the drug is either accepted or rejected. If accepted it is added to the drugs list. The system has the advantage that only drugs likely to be used are on the list and 'dead stock' is avoided. At the same time there is no regimentation of treatment and encroachment on the doctor's individual responsibility.

1035. BERGMAN, U., NORLIN, A. and WIHOLM, B.-E. **Inadequacies in hospital drug handling.** *Acta Medica Scandinavica*, Stockholm, 1979, vol. 205, no. 1-2, pp. 79-85.

When some routines for the prescription, recording and administration of drugs at Huddinge University Hospital, Sweden, were found to be inadequate, new procedures were developed, based on the following principles: (i) drug prescriptions, written and signed by the doctors/nurses, should include the indications for starting or stopping the treatment; (ii) no transcriptions of prescriptions were allowed; (iii) medication times were adapted to pharmacokinetic principles; and (iv) all doses taken by the patients were recorded and countersigned by a nurse. The system was tested over a three-month period in two medical wards. The 274 patients obtained 1,653 prescriptions, 83 per cent written by physicians, seven per cent of the prescriptions were never administered. Half the patients did not take all of the prescribed drugs. Prescribing errors of physicians were four per cent compared with 41 per cent under the old system. It is concluded that the principles of the test system allow increased safety and accuracy in drug handling. The recording of drug intake makes the evaluation of pharmacotherapy more reliable.

LABORATORIES

See also Abstract No. 962, 986, 1030

1036. DEPARTMENT OF HEALTH AND SOCIAL SECURITY and others. **Code of practice for the prevention of infection in clinical laboratories and post-mortem rooms.** (Chairman: Sir James Howie) London, Her Majesty's Stationery Office, 1978, ix, 75pp. £1.75

This Code is based on a draft submitted to the Working Party in the 'Laboratory

use of Dangerous Pathogens' in 1974 and in Public Laboratory Service Monograph No. 6 (1977)' 'The Prevention of Laboratory Acquired Infection'. Aspects covered include: application of the code and identification of specimens; staff and staff facilities; accommodation and laboratory procedures; safety cabinets; and infection hazards in individual specialties. A series of 14 appendices is included together with a selected list of references (pp. 69-70).

1037. **Conducting safety audits in the laboratory.** *Laboratory Equipment Digest*, London, 1979, Feb., vol. 17, no. 2, pp. 75, 77, 79.

Before conducting a safety audit in a laboratory, it is necessary to check on the presence of safety officers and the training in safety given to employees. The audit itself is made up of two parts: (i) the design of the buildings; and (ii) the services and amenities it contains. The greatest hazard is fire and precautions should include smoke-stop doors to protect escape routes and smoke detectors built into the alarm system. Careful consideration should be given to the storage of dangerous chemicals. Centrifuges should be serviced regularly as well as checked during audit. Guidelines for working with radiation are readily available and monitoring of laboratories equipment and staff must be of the highest standard. Exhaust protective cabinets must be provided when dangerous organisms are used. However conscientious laboratory staff officers may be, a safety audit conducted by an independent body is needed. Some case histories of potential hazards from the author's own experience are described.

1038. FLURY, P. A. **Environmental health and safety in the hospital laboratory.** Springfield, Ill., Charles C. Thomas, 1978, x, 183pp. $19.50

This book is intended as a practical guide on health hazards and safety. Aspects considered include: the law; the hospital environment; personal protective equipment; preventing laboratory fires; fighting fires; storage and handling of flammable liquids and compressed gases; and conducting inspections. The broad and in-depth coverage is presented so as to be comprehensible to the reader who has little or no experience in industrial chemistry. Tables, charts, lists and other reference material are included throughout the book.

DIAGNOSTIC X-RAY DEPARTMENT

1039. LINDSTROM, R. **Designing a shared radiology quality assurance program-Part one.** *Dimensions in Health Service*, Ottawa, 1979, Jan., vol. 56, no. 1, pp. 16-17.

After gathering data from 10 general hospitals, the author developed a shared quality assurance scheme for radiology departments in medium-sized hospitals. Representatives from the 10 hospitals met to consider their interest in joining the shared assurance scheme and the following factors were discussed: (i) existing quality control; (ii) needs assessment; and (iii) ideas on how the scheme should be operated. The author designed a testing and monitoring scheme in which four hospitals in the Fraser Valley area of British Columbia are now participating. He hopes his project will encourage the development of similar shared schemes throughout the province.

1040. LINDSTROM, R. **Implementing a shared radiology quality assurance program.** Part two. *Dimensions in Health Service*, Ottawa, 1979, Mar., vol. 56, no. 3, pp. 32-34.

The first part of this paper describes the development of a shared radiology quality assurance programme for hospitals in the Fraser Valley area of British Columbia. The second part describes its implementation. The parameters monitored are: automatic film processor sensitometry; regular cleaning and preventive maintenance; darkroom and safelights; screen maintenance and screen/film contact; viewbox and ambient conditions; collimation and beam alignment; focal spot size constancy; MaS and timer; KVP and filtration; image intensified/television resolution; contrast; tomographic apparatus; and repeat film analysis.

REHABILITATION

See also Abstract Nos. 940, 1028

1041. FRANKE, L. Das Zusammenwirken des Medizinischen Rehabilitationszentrums Schwedt (Oder) mit verschiedenen Bereichen bei der Lösung rehabilitativer Aufgaben. **[Collaboration between the Medical Rehabilitation Centre (Oder) and other services in completing the rehabilitation process.]** *Zeitschrift für die gesamte Hygiene und ihre Grenzgebiete*, Berlin, 1979, Jan., vol. 25, no. 1, pp. 57-61.

The Schwedt Medical Rehabilitation Centre, East Germany, occupies a converted hospital building and was opened in 1974. It has 55 places and a staff of 41 (including doctors, psychologists, teachers, nurses, occupational therapists, etc.); and include a 74-place home where educable children and young people are cared for on a daily or weekly basis, and a home (10 places) for mentally disturbed young people. Three groups of patients are admitted to the Centre: (i) mentally subnormal patients aged 14 to 25; (ii) physically handicapped patients age 14-55; and (iii) patients suffering from neurological and psychiatric illnesses (including brain damage, paralysis, multiple sclerosis and epilepsy). Care and treatment are provided in collaboration with hospitals, polyclinics, social services and housing departments, and other facilities. Of 150 physically handicapped patients so far admitted 95 per cent have been successfully rehabilitated and 76 per cent returned to work (97 per cent were still at work after a year); average length of stay was 110 days. Of 100 mentally handicapped patients 78 per cent have been successfully rehabilitated and 75 per cent were able to work: average length of stay was 294 days.

1042. HODEL, J., SCHÄRER, S. and STEINER, E. Berufliche Wiedereingliederung psychisch Invalider. Erste Resultate einer katamnestischen Untersuchung. **[Vocational rehabilitation of psychiatric patients: first results of a follow-up study.]** *Rehabilitation*, Stuttgart, 1979, Feb., vol. 18, no. 1, pp. 25-34.

A three-year follow-up study has been made of 78 patients admitted to the rehabilitation workshop at the Berne University psychiatric polyclinic's day hospital. It was found that 50 per cent of the patients who had practically no work capacity on admission were gainfully employed three years after completing the programme. Of the

total number 88 per cent were considered to be completely re-integrated into the community. The age of the patient at the onset of illness was important: if they were below 18, patients were less able to complete the training programme.

HYDROTHERAPY DEPARTMENT

1043. L'Insitut de thalassothérapie du Touquet: un véritable centre de soins. **[Le Touquet hydrotherapy centre: a real centre for providing care.]** *Argus des Collectivités*, Paris, 1979, Feb., vol. 27, no. 306, pp. 7-10.

The Hydrotherapy Institute in Le Touquet was designed by a local architect, M. Guetelart. General and local treatment is available in the form of baths and showers, using cold or heated sea water, bubble baths with micro- and macro-bubbles, underwater douches where water jets are directed at the body with varying pressure, low pressure showers used on their own or in conjunction with massage, and local applications of sea mud. The centre can treat 500 patients a day. It is linked by means of a covered walk to a swimming pool and a 100-bed hotel. A 12-day cure is recommended, in particular for patients with rheumatic diseases and post-traumatic disabilities.

DEPARTMENTS FOR SPECIAL THERAPY

See Abstract Nos. 983, 1009, 1060, 1067

SPECIAL HOSPITALS AND UNITS

OUT-PATIENT

See Abstract No. 1078

CASUALTY AND ACCIDENT

See also Abstract No. 1033

1044. Wood, A. M. **Flying doctor services.** *Injury*, Bristol, 1979, Feb., vol. 10, no. 3, pp. 170-174.

A flying doctor service deals with emergency medical problems either by taking assistance to the site of the emergency or by evacuating patients to a medical centre. It also takes teams of doctors, nurses and paramedical staff to peripheral medical units to carry out specialized surgery and to staff routine out-patient clinics and transport drugs, equipment, etc. The backbone of any flying doctor service is the radio link; in East Africa all 75 peripheral hospitals, mobile units and aircraft are connected by radio to control on the same three frequencies. The value of air transport in various parts of the world is discussed and the achievements of flying doctor services are outlined. Advice is given on setting up such a service.

1045. KESSLER, M. S. and WILSON, K. C. **Emergency department key factor in hospital admissions.** *Hospitals*, Chicago, 1978, Dec. 16, vol. 52, no. 24, pp. 87, 90, 92, 94.

A significant proportion of a community hospital's in-patient population is admitted through the emergency department. Administrators who are aware of the frequency of this practice in their hospitals can schedule and staff services more efficiently. A 1975 survey of 2,486 hospitals conducted by the American Hospital Association shows that the number of emergency department admissions depends on hospital size, location, ownership, and type of physician coverage in the emergency department. It is more difficult to quantify other relevant variables. Although the survey suggests that large hospitals treat the bulk of unscheduled in-patients, administrators and planners of hospitals of all sizes should recognize the extent to which admissions originating in the emergency department may influence care and costs throughout the hospital.

DAY HOSPITALS

See also Abstract Nos. 1054, 1079, 1080

1046. CREMERS, A. G. P. Beperking kosten klinisch systeem bereikbaar door 'dagverpleging'. **[Hospital costs can be reduced by greater use of the day care system.]** *Ziekenhuis*, Utrecht, 1979, Feb. 7, vol. 9, no. 3, pp. 58-62.

Admission to the 10-bed day unit of the 'De Weezenlanden' Hospital, Zwolle, is decided by the head of the admissions department in consultation with the patient and the attending specialist. Indications for admission are the growing number of treatments which require a general anaesthetic with little risk of complications, blood transfusions, etc. Polyclinical and pre-operative tests are carried out and patients are admitted for about eight to 10 hours. The wide range of specialties requires an experienced staff and the unit is manned by two trained nurses and a student, supervised by the head of the general services. A cost calculation based on 1,344 day unit patients during 1977 and a day unit fee of Fl.84.43 (appr. £21.10) showed a saving of fl.604,800 (appr. £151,200) when compared with the same cases if admitted to the hospital wards where their stay would have averaged 2½ days. The Weezenlanden has a bed occupancy of approximately 96 per cent and the unit, by taking nine per cent of the total number of admissions, relieves the wards, thus enlarging the capacity of the hospital. For hospitals with a low bed occupancy a day unit would be less commendable. The paper includes a ground plan of the unit, a list of treatments given during 1975 to 1977 inclusive, a list of specialties and a table of day unit costs during 1977.

1047. EDWARDS, D. W., YARVIS, R. M. and MUELLER, D. P. **Evidence for efficacy of partial hospitalization: data from two studies.** *Hospital & Community Psychiatry*, Washington, D.C., 1979, Feb., vol. 30, no. 2, pp. 97, 101.

Two studies were carried out to examine the use and effectiveness of hospital day treatment for psychiatric patients in Sacramento County, California. The first group studied comprised 108 consecutive admissions to a 3-day treatment scheme, 50 per cent of whom had previously been in-patients. The second group consisted of 90 consecutive admissions, 41 of whom had been in-patients. There were no significant differences in

levels of impairment between the two groups. The results of the studies showed that day treatment produced significant improvements in both groups, irrespective of whether they had previously been in-patients, and the level of improvement was maintained between the last visit and a three-month follow-up. Fewer than five per cent of the total number of patients were re-admitted within two years of ending day treatment. These results show that day treatment can help prevent re-admission and improve rehabilitation of the severely impaired patient.

INFECTIOUS DISEASES AND ISOLATION

1048. BRUUN, J. N. Isolasjon av smittefarlige pasienter i sykehus, behov for isolasjon og plassering av isolasjonsenhetene. **[Isolation of hospital patients with infectious diseases; the need for isolation and the location of isolation units.]** *Sykehuset*, Oslo, 1979, vol. 42, no. 1, pp. 69-74.

The requirement for isolation beds is separately estimated in Denmark, Sweden and America to be between 10 and 20 per cent of the total beds in the hospital, being greatest on surgical, medical and children's wards, and least (10 per cent) on wards for non-infectious diseases. Since the need for specially isolated surgical beds is estimated at 0.03 per cent of the population in Sweden and 0.01 per cent in Denmark, a figure of 0.02 per cent is regarded as being appropriate to Norway, or 500 to 1,000 beds. The isolation units currently found in four hospitals in Norway do not cover this requirement. Trivial infections and certain serious cases should be isolated on the patient's own ward. Isolation wards with their own specially trained staff should be established for such serious diseases as require them. Each room must have its own toilet, shower and decontamination unit, with air-locks between room and corridor. Correct isolation requires expert knowledge of the mode of infection of the various diseases. The staff's expertise should be placed at the disposal of other wards. Isolation departments in Norway will be established as sub-sections of larger internal medical wards. Such sections will be responsible for the isolation of seriously infectious disease cases, cases of highly infectious cross-infection, epidemic cases and cases of protective isolation. Certain diseases such as smallpox, Lassa fever and Marburg virus disease require separate buildings; none such exist at present in Norway.

CHILDREN

See also Abstract Nos. 941, 942, 1029, 1081, 1082

1049. HUBER, A. Wir wissen zu wenig über Kinder im Krankenhaus Modelle und Analysen sollen Situation aufhellen. **[We know too little about children in hospital: models and analyses should help.]** *Krankenhaus*, Stuttgart, 1978, Dec., vol. 70, no. 12, pp. 457-460.

In this paper the West German Federal Minister for Youth, Family and Health discusses the problems for the child, the family and the hospital associated with the admission of children as in-patients. Not enough is known of the inter-relationships involved or of what is required in the way of hospital organization to ensure that the best interests of children are served. The Minister outlines a research project which

she has commissioned and which she regards as a first step towards improving the care of children in hospital. The project has three facets: (i) the hospital: an analysis of specific forms of organization, working conditions and qualification characteristics in relation to their importance for contact with parents; (ii) the parents and families of mentally ill children; a study of the social structure and living conditions of parents and the effect on the family of having a child in hospital; and (iii) a linking of the first two facets by a study of selected cases of the inter-relationships between child and hospital.

1050. KRAHE, H. Ein Beispiel: Kinderkrankenhaus Dottendorf. **[An example: the Children's Hospital, Dottendorf.]** *Krankenhaus*, Stuttgart, 1978, Dec., vol. 70, no. 12, pp. 460-466.

The 50-year-old children's hospital at Dottendorf, a suburb of Bonn, has 250 beds. While adequately covering the whole field of paediatrics it specializes in intensive care, neurology and surgery. It has its own school of nursing, rehabilitation department and patients' school. There are facilities for mothers to be admitted with their children, and visiting is allowed at any time. Regular visits are made to kindergartens to tell 'future patients' about hospitals and to relieve their fears about entering hospital. In spite of the fact that the Dottendorf hospital has an average bed occupancy of 90 per cent, that it admits patients unable to find a bed in other hospitals, and that it is the only children's hospital in the Federal capital, the authorities have ruled that there is an excess of paediatric bed capacity in Bonn and that Dottendorf hospital is not needed.

1051. ROSENKVIST, I. Børn og hospital/7: kontakten til hjemmet opretholdes og afskeden forberedes i god tid. **[Children in hospital 7: they keep up home contacts and are prepared for departure in plenty of time.]** *Sygeplejersken*, København, 1979, Mar. 21, no. 12, pp. 12-15.

About 100 Eskimo children from Greenland are admitted to the national teaching hospital Rigshospitalet every year. They are placed on a medical paediatrics ward which has 12 beds, for children from three months old to about 16 years. The diagnoses requiring transport across the Atlantic from Greenland hospitals are primarily cardiac diseases and epilepsy; a smaller group comprise psychomotor retardation, certain malignant conditions (mostly leukaemia) and orthopaedic surgery cases. Their stay in hospital is usually long, because they are not discharged until completely cured. An interpreter from the Ministry of Greenland Affairs and members of a team of Greenlanders visits the ward every day, and a number of bilingual posters has been prepared describing the routines of normal civilized life. Besides linguistic difficulties, problems are experienced in acclimatization to European foods, to the institutions of medical therapy, and to staying indoors for long periods. The medical staff send a report home on the child's progress once a month, and the telephone is also available in an emergency. On discharge, the patient and parents are prepared in good time, and the child is flown home with a nurse selected by the Ministry. Treatment is on a team basis, to prevent over-close attachments to individual members of staff. The experience gained in the department is being applied to the treatment of Turkish, Pakistani and other foreign children. The article is illustrated with eight photographs taken on the ward.

GERIATRICS AND LONG-STAY

1052. EDOUARD, L. and others. Kateterfri långvårdsavdelning—ett vårdexperiment. **[A catheter-free long-stay ward—report on a two-year experiment.]** *Sjukhuset*, Göteborg, 1979, vol. 56, no. 2, pp. 71-74.

In January 1977, the staff of Clinic I, Vasa Hospital, Gothenborg, a long-stay clinic for people over 74 years of age, decided to introduce medical anti-incontinence measures instead of in-dwelling catheterization, unless absolutely necessary. Out of 262 patients covered by the two-year trial, it was possible to discharge 108 (42 per cent) home or to a service unit, and 96 (37 per cent) to a nursing home. Once the new routines had been established, patients, their relatives, and staff much preferred the present, catheter-free method of treatment. Cross-infection has dropped to a minimum. Despite the high patient turnover (early discharge of previously long-term cases) staff turnover was negligible. The net cost of treating patients dropped from s.kr. 7.97 per patient per 24 hours to s.kr. 4.64. It is argued that in-dwelling catheters are a source of cross-infection and are used too much in hospital treatment.

1053. SIMONEN, H. and others. **The long-term treatment of the aged: an assessment method.** *Scandinavian Journal of Social Medicine*, Stockholm, 1979, vol. 7, no. 1, pp. 27-32.

The aim of this investigation was to construct three parameters and assess their value as admission criteria for long-stay institutional care of the aged: medical dependence, nursing dependence, and dementia. The study involved 200 applicants for admission, of whom 150 were admitted to institutions. Both dementia and nursing dependence were found to increase with age, and there was a highly significant correlation between nursing dependence and age. There was also a highly significant correlation between nursing dependence and degree of dementia. The test results of dementia were used as the sole, decisive criterion in 24 per cent of admissions, medical dependence in 22 per cent and nursing dependence on 15 per cent. Two or three parameters were used in 39 per cent of admissions—all indicating the same type of institutional care. The simultaneous use of the assessment criteria provides an extensive body of information as to the general need of care, and by means of this information the appropriate placement of the elderly will be made possible.

1054. GREENE, J. G. and TIMBURY, G. C. **A geriatric psychiatry day hospital service: a five-year review.** *Age and Ageing*, London, 1979, Feb., vol. 8, no. 1, pp. 49-53.

A five-year review of two day hospital units attached to a large psychiatric hospital in Glasgow is described. Data are presented for two diagnostic groups, organic and functional. The annual rate of admission to the day hospital of patients with functional diagnoses has declined, while organic cases have increased to a current 80 per cent, of whom 65 per cent are over 75 years old. The majority of organic patients stayed for a short time and were discharged to a psycho-geriatric ward. Thus the main role of the day hospital has not been to avoid admission or hasten discharge, but to provide short-term support to those awaiting long-stay beds. The length of period of attendance

and the destination on discharge from the day hospital were not affected by the patient's domestic situation. In areas where long-stay beds are in short supply, day hospitals require a substantial increase in revenue in order to develop more comprehensive programmes of patient management.

NEUROLOGY AND NEUROSURGERY

1055. MILLS, E. and THOMPSON, M. **The economic costs of stroke in Massachusetts.** *New England Journal of Medicine*, Boston, Mass., 1978, Aug. 24, vol. 299, no. 8, pp. 415-418.

This paper presents and examines the following statistics for strokes in Massachusetts in 1975: estimated incidence by age and sex; expected post-stroke earnings; and costs of strokes. The following points emerge: (i) 76 per cent of all costs derive from strokes occurring in people over 65 years of age; (ii) indirect costs constitute 46 per cent of all costs; (iii) the severe economic burden of strokes among those of intermediate age; (iv) the direct costs of stroke come to 50.4 per cent of state health expenditure on alcohol abuse; and (v) direct costs of stroke were 72.3 per cent of the economic costs of smoking and the indirect costs 49.7 per cent of those for smoking.

1056. MACKAY, A. and NIAS, B. C. **Strokes in the young and middle-aged: consequences to the family and to society.** *Journal of the Royal College of Physicians of London*, London, 1979, Apr., vol. 13, no. 2, pp. 106-112.

This paper explores factors that may predispose to stroke in patients under 65 years of age and examines the ensuing costs to the patient, his family, the hospital services and society. From the data presented, young patients with stroke are expensive for the National Health Service. It also appears that the major determinant of costs is the duration of hospital stay. Two suggestions are made: (i) a large saving could be made by early transfer from an acute bed to a long-stay/rehabilitation bed; and (ii) excepting those cases where intensive nursing is required, those who are minimally disabled could be cared for at home, perhaps after initial hospital out-patient assessment and with continuing out-patient review.

CARDIOLOGY

1057. KINROSS, V. **What is the worth of a coronary care ambulance?** *Middle East Health*, Sutton, 1979, Mar., vol. 3, no. 3, pp. 55-56.

Coronary care ambulances are the cause of much debate because, while they save some lives, pilot schemes have indicated that a large-scale introduction of such a service may not justify the expense involved. Three coronary care ambulances are in use in the Pulborough fleet, in East Sussex, financed by the local Arun Cardiac Emergency Fund which now totals about £20,000. Each ambulance is equipped with American machines which are a combination of heart monitor, recorder and defibrillator. A heartbeat pattern is relayed via a radio link to demodulators in the three main hospitals in the area. A 12-lead ECG is to be installed soon. Basic training in the use of resuscitation and monitoring equipment was carried out in conjunction with two local hospitals. The most successful national solution to the question of mobile coronary care units would be the development of a two-tier ambulance service.

1058. KIRCHHOFF, P. G. and BAUMGARTEN, C. Spezielle anforderungen der Kardiochirurgie an Pflege- und Behandlungseinheiten. **[Special heart surgery requirements in wards and treatment units.]** *Krankenhaus*, Stuttgart, 1978, Oct., vol. 70, no. 10, pp. 396-399.

The patient undergoing treatment and surgery for heart conditions is exposed to special infection risks. This paper outlines the principal dangers which arise in this area. Heart operations take a long time and there is the risk of infection in the use of such equipment as the heart-lung machine. There are also additional risks because of the number of staff present in the theatre during heart operations. It is important to isolate short-term patients from long-term patients needing mechanically assisted circulation. Often a longer stay in the recovery room is necessary after heart operations with a consequent increase in the risk of infection. Suitable measures must be taken to counteract these hazards.

UROLOGY

See also Abstract No. 983

1059. FROTSCHER, U. Hygienische Anforderungen an die bauliche Gestaltung von Dialysestationen. **[Hygiene requirements for the structural design of dialysis units.]** *Krankenhaus*, Stuttgart, 1978, Oct., vol. 70, no. 10, pp. 401-403.

In spite of recent improvement there is still a high rate of mortality from infection among dialysis patients. This paper distinguishes four types of dialysis: acute dialysis, where there is contact with other patients and where patients have secondary diseases—here the standards are those of an intensive care unit; 'hospital dialysis', where there is contact with other patients and where patients have complications—here the standards required are those of an operating suite or an infectious diseases unit; 'limited care', where patients are otherwise 'healthy' and have little contact with other patients—here the standards are those of a sanitorium; and home dialysis, where there is no contact with other patients and the standard is that of a home. The hygiene requirements for each type are outlined. A sketch plan of a suitable design for a hospital dialysis ward is included.

1060. BIRRELL, D. J. and others. **An epidemic of chloramine-induced anaemia in a haemodialysis unit.** *Medical Journal of Australia*, Glebe, 1978, Sept. 23, vol. ii, pp. 288-290.

A sudden fall in blood haemoglobin concentration occurred in approximately half the patients undergoing dialysis at the Royal Brisbane Hospital during January 1977. This coincided with the reintroduction of chloramine as a disinfectant in the public water supply. The patients could be divided into two groups on the basis of presence or absence of Heinz bodies in red blood cells; the groups were found to differ in transfusion requirements, in the degree of fall in haemoglobin concentration, and in reticulocyte response. After the addition of a carbon filter, the mean haemoglobin concentration rose to pre-chloramine levels. Medical directors of haemodialysis units should be informed by water boards of changes in the method of disinfecting water.

SURGERY

See also Abstract No. 1058

1061. McCarthy, E. G. and Finkel, M. L. **Second opinion elective surgery programs: outcome status over time.** *Medical Care*, Philadelphia, 1978, Dec., vol. 16, no. 12, pp. 984-994.

The second opinion elective surgery programme is designed to screen patients before they undergo surgery to review the need for it. Only one programme, conducted by Cornell University Medical College, New York, has accumulated any meaningful statistics of the 7,274 individuals who have participated in the programme since its inception, 27.6 per cent were not confirmed for surgery. This analysis focuses on this group one year after their second opinion consultation and compares them with a similar number who were confirmed for surgery. Roughly 77.9 per cent of the not confirmed cases had not had surgery, and of these 64.4 per cent reported no medical treatment. Of the 710 not confirmed cases, one-third never reported receiving medical treatment. Although the majority of the confirmed cases did have surgery 25.4 per cent had not surgery one year after their consultation. The findings indicate the programme's ability to screen potential surplus surgery and realize cost savings. Subsequent follow-up studies will present a clearer, more accurate assessment.

1062. Fuchs, V. R. **The supply of surgeons and the demand for operations.** *Journal of Human Resources, Education, Manpower and Welfare Policies*, Madison, Wisc., 1978, vol. 13, supplement, pp. 35-56.

This paper presents a multiequation, multi-variate analysis of differences in the supply of surgeons and the demand for surgical operations across geographical areas of the United States. Despite some shortcomings in the data, the findings strongly support the hypothesis that an increase in the supply of surgeons results in an increase in the demand for operations. Surgeons have considerable discretion in choice of location and their distribution is determined partly by their preferences as consumers. Thus geographical areas differ in their surgeon/population ratio for reasons unrelated to the inherent demand for operations. Other things being equal a 10 per cent higher surgeon/population ratio results in an increase of about 10 per cent in the number of operations and an increase in price. Thus, the average surgeon's workload decreases by seven per cent, but income per surgeon declines by much less.

1063. Dixon, E. **Design for 2001.** *Nursing Mirror*, Sutton, 1979, Mar. 15, vol. 148, no. 11, pp. xii, xv.

The author outlines probable changes in surgery in the next century. As more adventurous procedures are carried out nurses will need more technical and, at the same time, more psychological training. Hopefully theatre nurses will receive financial rewards commensurate with the skills required. They will also need to understand the research involved in the development of new surgical techniques. These techniques will probably include an increased number of transplants, increased use of lasers and the continued use of fibre optic endoscopy and ultrasonic scanning as aids to investigation and diagnosis. There is likely to be more use of hypnosis and acupuncture in

anaesthesia. Test-tube babies and euthanasia will continue to be discussed. These developments will be accompanied by a greater awareness on the part of operating theatre staff of (i) the importance of budgeting and (ii) the patient's entitlement to legal proceedings. Successful surgery at any time can only be achieved by team effort in a scrupulously clean environment.

MATERNITY

See also Abstract Nos. 951, 1007-1009, 1011

1064. NEUBÜSER, D. Hygieneprobleme beim "rooming-in". **[Problems of hygiene associated with rooming-in.]** *Krankenhaus*, Stuttgart, 1978, Dec., vol. 70, no. 12, pp. 477-479.

The rooming-in system for maternity hospitals is defined and the different methods (full or partial) described. From the point of view of hygiene the greatest risk is the exposure of the newborn child to hospital-specific micro-organisms. Such micro-organisms are more likely to be transmitted by hospital staff and by instruments and apparatus; rooming-in does not increase the risk. Nonetheless hygienic measures must be taken during rooming-in to ensure that the transmission of infection from one infant to another is, as far as possible, prevented. Instruments and apparatus for treatment and care should always be used for one infant only: when this is not possible there must be adequate disinfection. Nursing staff should have a separate gown for each infant they look after. Hand hygiene to prevent the spread of staphylococcal and other infections is of decisive importance. Two years' experience of rooming-in at a Giessen Hospital has shown that the infection rate among the newborn is no higher than with traditional procedures.

1065. NOTELOVITZ, M. **The single-unit delivery system—a safe alternative to home deliveries.** *American Journal of Obstetrics and Gynecology*, St. Louis, 1978, Dec. 15, vol. 132, no. 8, pp. 889-894.

The single-unit delivery system was introduced into the Department of Obstetrics, Addington Hospital, Durban, South Africa in 1970. It is designed to provide both safe and 'private' deliveries by: (i) screening prenatal patients into categories of risk; (ii) using a single room for labour and delivery; and (iii) providing close supervision of normal labours by trained midwives and electronic monitoring systems. Each unit is self-contained and equipped to deal with most obstetric procedures. The unit has 24-hour coverage by medical staff, and physicians are directly responsible for the management of high-risk and complicated labours. The single-unit delivery system has proved in practice to be an effective method of providing safe and satisfying obstetric care without compromising modern obstetric standards. Its introduction requires the re-designing of the labour and delivery area and depends upon a plentiful supply of midwives.

1066. REYNOLDS, D. **Mum's the word for babies in hospital.** *Nursing Mirror*, Sutton, 1979, Mar. 29, vol. 148, no. 13, pp. 20-22.

The special care baby unit at High Wycombe General Hospital is notable for two features: (i) its enlightened design, which enables mothers to stay constantly with their

premature and sick babies and to care for them; and (ii) the quality of care and involvement by the medical staff. The most important feature of the unit are the eight small mothers' rooms, which are modestly but comfortably furnished. At the end of each room is a cubicle, heated to a considerably high temperature, where the baby can be cared for by his mother. The advantages of mothers living in the unit are discussed.

1067. VAIZEY, J. and OPPE, T. E. **Study of special-care baby services in North-West Thames Region.** *British Medical Journal*, London, 1979, Mar. 3, vol. i, pp. 583-585.

During three months of 1975, admissions to 17 of the 21 special care baby units in the North-West Thames Region were analyzed by birth weight and category of care required. Of the 1,718 babies admitted, 643 needed observation only and considerable variation in the pattern of admissions was found. There was some degree of centralization in the care of the sick newborn of low birth weight, but in most units an undue proportion of the work load was taken up by babies not requiring intensive care. It is concluded that the quality of care given to some infants needing intensive care could be improved by a greater concentration of skills in a few units. In addition, some units should review their admission policies to prevent unnecessary postpartum separation of mother and baby.

PSYCHIATRY

See also Abstract Nos. 998, 1042, 1047, 1054

1068. COHEN, C. I. **Prospects for change in public mental institutions.** *International Journal of Social Psychiatry*, London, 1978, vol. 24, no. 4, pp. 263-270.

The author maintains that it is impossible to create a true therapeutic environment within a psychiatric hospital because of the incompatibility of various factors, such as staff and patient roles and the needs of the hospital. In many institutions patients are admitted involuntarily and this, together with the lack of clarity regarding the treatment of mental illness, may put the patient at odds with the doctors and other staff. In addition, staff personalities and needs often clash with the expectations of milieu therapy, and altering the environment is not enough to guarantee therapeutic success. This is so because: (i) staff may not understand the reasons for a change away from custodial therapy; (ii) the milieu approach has given little attention to nurse education; (iii) factors such as large wards and shortage of staff make the change difficult; and (iv) staff have not been given sufficient motivation or financial rewards for taking on new roles.

1069. TALBOTT, J. A. **The death of the asylum: a critical study of state hospital management, services, and care.** New York & London, Grune & Stratton, 1978, xiv, 185pp. £14.60

This book presents a critical examination of the inadequacy of public care for the severely and chronically mentally ill, and the inability of state hospitals to provide quality care in the United States. The author considers the sociology, economics and politics of the state hospital system from colonial times to the present day. There are five parts: (i) an historical overview; (ii) the problems of why state hospitals do not function adequately; (iii) the need for change for the better in the state hospitals;

(iv) possible solutions to the problems; and (v) the future of state hospitals. References are given at the end of each chapter.

1070. WHITE, S. L. **The community mental health center as a matrix organization.** *Administration in Mental Health*, New York, 1978, vol. 6, no. 2, pp. 99-106.

The author reviews briefly the literature on the design of matrix organization as applied to industry and the social services. The article describes how the matrix design, which involves the superimposing of special projects upon an existing departmental structure, may be applied to a community mental health centre. The phases of its practical application in the Westside Community Mental Health Center, Tampa, Florida are described. Here a Clinical-Executive Committee identified organizational needs and established sub-committees to develop new programmes and revise existing ones. This centre, by using the matrix system, was able to expand services, reduce staff and increase productivity within one year.

1071. GLICK, I. D. and HARGREAVES, W. A. **Hospitals in the 1980's: service, training, and research.** *Hospital & Community Psychiatry*, Washington, D.C., 1979, Feb., vol. 30, no. 2, pp. 125-128.

Pressures for change in psychiatric hospitals arise from: (i) data from recent controlled studies of outcome of different approaches and length of stay; (ii) changes in the social-political-economic climate; and (iii) new methods of organizing the delivery of services. It is proposed that the primary use of in-patient accommodation should be for brief treatment (three to 21 days); for a very small group, longer in-patient care may be needed. The hospital will also be used for triage and disposition of persons with a broad range of problems which may rarely take more than three days. Complementary changes will be required in training and research. A promising training model may consist of continuous care teams by which trainees can manage chronic multi-problem patients through different levels of care within and outside the hospital. Research must move to out-of-hospital settings if the new patterns of care are to be understood and improved.

1072. HERZ, M. I. **Short-term hospitalization and the medical model.** *Hospital & Community Psychiatry*, Washington, D.C., 1979, Feb., vol. 30, no. 2, pp. 117-121.

In recent years there has been a significant decrease in the length of stay of psychiatric patients. The author examines whether the shorter stays are justified by results of controlled studies and, if so, what is the most appropriate hospital milieu for short-stay units. He summarizes several studies supporting his opinion that short-stay hospital care is usually indicated for the majority of patients, provided that continuity of care is ensured and that supervized living arrangements are available for patients who require them. A medical-model milieu with a clear structure and delineation of roles is considered to be most appropriate for short-stay in-patient units.

1073. KLERMAN, G. L. **National trends in hospitalization.** *Hospital & Community Psychiatry*, Washington, D.C., 1979, Feb., vol. 30, no. 2, pp. 110-113.

The past two decades have witnessed several important trends in mental health care in the United States: a decline in the number of patients in public psychiatric hospitals; an increase in out-patient treatment and facilities; relative stability in the number of

admissions per 100,000 population; and shorter length of stay. The combined result of these trends is increased pluralism, diversity and deinstitutionalization in mental health care. The changes are primarily the consequences of the success of psychopharmalogical agents, new forms of psychotherapy, changing attitudes of the public and the profession, and increased financial support from the federal government.

1074. INSKIP, J. H. and EDWARDS, J. G. **Mental hospital inquiries.** *Lancet* London, 1979, Mar. 24, vol. i, pp. 658-660.

Major inquiries into the running of hospitals burn up money that is desperately needed to improve the National Health Service, disrupt the work of the hospital, and often have a devastating effect on individual and group morale. Many inquiries could have been prevented if warning signs had not been ignored and decisive action had been taken earlier. This paper first focuses on the problem of decision taking. It examines three interlocking aspects of medical staff responsibility in decision taking: the range of medical responsibility; manpower and material shortages; and leadership. The second part of the paper considers how a committee of inquiry functions, the examination of witnesses, the effects on staff morale and right of appeal.

1075. PHILLIPS, M. **Nursing in a forensic unit.** *Dimensions in Health Service*, Ottawa, 1979, Feb., vol. 56, no. 2, pp. 28, 30-31.

The Clarke Institute of Psychiatry, Toronto, has a forensic service comprising an out-patient and in-patient unit and a family court division. The in-patient section accommodates 22 patients, both men and women. The organization and work of the service are outlined. The forensic nurse has to help patients to redirect their energy more constructively. She carries out individual psychotherapy as a primary therapist, and a variety of group therapies either as a leader or co-leader. The educational needs of nurses in the service are outlined.

1076. PALLIS, D. J. **Psychiatric treatment: the question of attitudes.** *International Journal of Social Psychiatry*, London, 1978, vol. 24, no. 4, pp. 281-286.

This paper discusses the attitude towards psychiatric treatment of certain groups of people involved in psychiatric care. Psychiatrists in general have two approaches to treatment, an 'analytical' and an 'organic' approach, the choice depending to a certain degree on individual personality and type of training. There appears to be greater agreement between nurses and patients regarding the value of particular psychiatric treatments than there is between patients and doctors or social workers, but generally nursing staff reflect the overall treatment preference of a particular hospital rather than have any influence upon it. Social workers are most likely to adopt a 'socio-therapeutic' approach to psychiatric care and may disagree with psychiatrists to the detriment of the patient. Patients' individual characteristics and social attitudes must be considered when deciding upon an acceptable treatment plan. Hopefully the increase in scientific treatments for defined psychiatric problems will soon overcome the tendency to rely on personal choice.

1077. MAGUIRE, L. **Peer review in community mental health.** *Community Mental Health Journal*, Washington, D.C., 1978, vol. 14, no. 3, pp. 190-198.

The medical origins of the peer review legislation and its adaptation to community

mental health centres are outlined. Three models of peer review which could be used in community mental health centres are presented: (i) the problem model, in which the committee concentrates its efforts on the stated problems, goals or diagnoses of the patients; (ii) the sequential model, which involves following the patient along the normal course of care through the centre; and (iii) the Psychiatric Utilization Review and Evaluation Project at Yale, carried out at three levels, with the involvement of non-clinicians at the first two levels.

1078. SINGH, A. J., MESSICK, J. M. and MAY, P. R. A. **Staffing an outpatient program: evaluation of work load and cost.** *Administration in Mental Health*, New York, 1978, vol. 6, no. 2, pp. 120-132.

This article describes a system study and a time study to assess the work load, cost and staffing needs of a psychiatric out-patient clinic operated by staff who are also involved in in-patient care. Using systems analysis a study was carried out on the out-patient unit which operates two main programmes of day care and follow-up visits. The time study determined how nursing staff time was distributed between in-patient and out-patient care and between direct and indirect care within the out-patient clinic. The following factors were revealed by the time study: (i) 45 per cent of nursing time was spent in indirect care activities; (ii) nursing staff spent 33 minutes in patient contact for each day care visit and 48 minutes for each follow-up visit; (iii) the cost of a day care visit was slightly lower than that of a follow-up visit; and (iv) all levels of nurses gave all types of patient care services. The study enabled staff to understand how the out-patient clinic functioned, and 20 hours indirect nursing time was saved by delegating some administrative duties to the out-patient clerk.

1079. MUENCH, H. **Advantages of psychiatric day care.** *Dimensions in Health Service*, Ottawa, 1979, Feb., vol. 56, no. 2, pp. 39-40.

The development of day care at the 524-bed St. Thomas (Ont.) Psychiatric Hospital is outlined. The present service provides psychiatric and supportive services for patients who come to the scheme several times a week, spend a major part of the day there and return home to spend the night. The programmes include: recreational services (physical activities, crafts and related activities, music, and library); vocational services (industrial workshop, hospital services, and vocational rehabilitation counselling); and volunteer services, designed to bring patients and community closer together.

1080. MILLER, D. L. and WILDER, J. F. **Multimodal outpatient group treatment for the psychiatrically disabled.** *Community Mental Health Journal*, Washington, D.C., 1978, vol. 14, no. 3, pp. 209-215.

Psychiatric out-patient clinics gradually accumulate patients with long-standing disabilities. The traditional treatment approach is to see such patients in brief, intermittent, individual visits. Staff generally dislike treating such patients and patients may, in part, maintain their symptoms in order to maintain ties with a nurturing institution. The Bronx Municipal Hospital Center, New York, has explored an alternative approach—weekly group meetings using a number of helping modalities. This paper describes the characteristics of the sample of 34 patients treated by this approach and their weekly group meetings, and presents assessments of this approach

by staff and patients. Although no panacea, the approach appears to provide a reasonably effective, efficient, and enjoyable way of helping chronically disabled psychiatric patients.

1081. FIESTER, A. R. **The access system: a procedure for evaluating children's services at community mental health centres.** *Community Mental Health Journal*, Washington, D.C., 1978, vol. 14, no. 3, pp. 224-232.

The automated comprehensive children's evaluation system (ACCES) was designed by the Community Mental Health Center of Palm Beach County, Fla., to meet simultaneously the needs of providing data on: patterns of use of children's services; availability, accessibility, acceptability and consumer satisfaction with services; and the overall impact (effectiveness) of services on its catchment area clientele. The core of the system is the basic goal attainment format with considerable modification. There are three phases in the procedures: establishment of goals; therapist rating of outcome; and client follow-up. The forms used have been designed so that they can be quickly scanned and forwarded to the data processing department where they are processed by a card-reading IBM System 3, Model 10 high speed computer. The software is written in Report Program Generator language. Initial results from the system are presented.

1082. COYE, J. I. **Children's rights in Michigan: new law and old paternalism.** *Hospital & Community Psychiatry*, Washington, D.C., 1979, Feb., vol. 30, no. 2, pp. 132-134.

A variety of civil, treatment and environmental rights of patients in Michigan's state psychiatric hospitals, private facilities and community mental health services are protected by the state's mental health code. Any complaint of a violation of rights must be investigated; if it is substantiated, remedial action must be taken and must be reported to the complainant. The complaints from children in hospitals, or from others acting on their behalf, centre around three major rights: protection from abuse, treatment suited to condition, and a safe, hygienic and humane living environment The author discusses a number of problems that the State Office of Recipient Rights has encountered in dealing with alleged violations of children's rights.

1083. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. COMMITTEE OF INQUIRY INTO NORMANSFIELD HOSPITAL. **Report.** (Chairman: M. D. Sherrard). (Cmnd. 7357) London, Her Majesty's Stationery Office, 1978, xiv, 464pp. £6.75

The terms of reference of this inquiry were: to enquire into patient care and staff morale at Normansfield Hospital, Teddington, Middx., and in particular into complaints made by staff at the hospital and others; to enquire into the causes and effect of unrest at the hospital and the action taken to deal with the situation; and to make recommendations. The report indicates that there is a need to redefine the meaning and operation of consensus management and the role of individual members of management, including clinician members. It also demonstrates the need for health authorities and their officers to act decisively in awkward situations. Aspects considered by the inquiry include: the hospital; management; community health council; dental care and hygiene; domestic services; nursing; accidents; morale; and medical treatment. Recommendations are made regarding the buildings; nursing staffing; medical staffing; local authority liaison; and the attitude of the Department and the NHS Authorities.

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